STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395661	A. Building B. Wing	03/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Casselman Healthcare and Rehabilitation Center	201 Hospital Drive Meyersdale, PA 15552

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 19102 Based on review of facility policies, clinical records, and investigation documents, as well as staff interviews, it was determined that the facility failed to ensure that residents were free from abuse for one of seven residents reviewed (Resident 4). Findings include: The facility's policy for abuse, dated January 31, 2024, indicated that residents had the right to be free from abuse, neglect, misappropriation of resident property, corporal punishment, and involuntary seclusion. Abuse was defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Willful meant the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 1, dated January 23, 2024, indicated that the resident was usually understood and could usually understand others, was cognitively intact, had no behaviors, and had diagnoses that included anxiety (feeling of fear, dread, and uneasiness). A care plan, dated October 16, 2023, revealed that Resident 1 had behaviors and staff were to intervene as necessary to protect the rights and safety of others. A quarterly MDS assessment for Resident 4, dated February 24, 2024, revealed that the resident was understood, understands, exhibited physical and verbal behavioral symptoms directed towards others which occurred one to three days during the review period, and had a diagnosis which included multiple sclerosis (MS - a chronic disease of the central nervous system) and cerebral vascular accident (CVA - commonly referred to as a stroke). A nursing note, dated February 12, 2024, at 4:08 p.m. revealed that Resident 1 was involved in an altercation with another resident. Resident 1 stated, I was sitting here at the table talking to another resident when Resident 4 started wheeling into the dining room, and I said 'here comes Resident 4'. Then Resident 4 kept bumping into my chair, and I told him to stop, but he kept doing it, so I hit him. The resident demonstrated the motion, and claimed it was an open-handed hit. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395661	A. Building B. Wing	03/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Casselman Healthcare and Rehabilitation Center	201 Hospital Drive Meyersdale, PA 15552

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A nursing note for Resident 4, dated February 12, 2024, revealed that the resident had a small scleral abrasion (an area damaged by scraping or wearing away) of the right eye with surrounding subconjunctival hemorrhage (a broken blood vessel in the eye). A new order was received for erythromycin ointment (a topical antibiotic) three times per day for seven days. The facility report, dated February 12, 2024, indicated that an event occurred on February 12, 2024, at approximately 1:30 p.m. when Resident 4 wheeled himself backwards into the dining room and Resident 1 became upset because Resident 4 bumped his wheelchair into Resident 1. Resident 1 turned his wheelchair to the side and slapped Resident 4 on the right side of his face, causing Resident 4 to have a blood shot eye. Resident 4 was assessed by the certified registered nurse practioner (CRNP - a registered nurse (RN) who has advanced education and clinical training in a health care specialty area) and an order was received for an eye ointment for the redness noted in his eye. A statement from Resident 1 regarding the incident on February 12, 2024, undated, revealed that he was sitting at the table talking to another resident when Resident 4 started wheeling into the dining room. Resident 4 kept bumping into his chair and he told him to stop, but Resident 4 kept doing it and he hit him. Resident 1 claimed it was an open-handed hit. A statement from Resident 4 regarding the incident on February 12, 2024, undated, revealed that he came around the corner of the dining room and Resident 1 stated, Here comes that damn Resident 4. Resident 4 said that he did not do anything so he did not know why Resident 1 was running his mouth. Resident 4 did accidentally bump into Resident 1's chair and then Resident 1 hit Resident 4 with a fist. A statement from Resident 7, undated, revealed that Resident 4 bumped into Resident 1's chair and then Resident 1 swung at him, which started as a fist but he could not quite reach him, so Resident 1's hand opened as it made contact. Interview with the Nursing Home Administrator on March 26, 2024, at 4:24 p.m. confirmed that Resident 1 did hit Resident 4. 28 Pa. Code 201.14(a) Responsibility of Licensee. 28 Pa. Code 201.18(b)(1)(e)(1) Management. 28 Pa. Code 201.29(j) Resident Rights.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395661	A. Building B. Wing	03/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Casselman Healthcare and Rehabilitation Center	201 Hospital Drive Meyersdale, PA 15552

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 31760 Based on review of facility policy and clinical records, as well as staff interviews, it was determined that the facility failed to ensure that a resident's care plan was updated/revised to reflect the resident's specific care needs for four of seven residents reviewed (Residents 1, 2, 4, 6). Findings include: A facility policy regarding plans of care, dated January 31, 2024, indicated that resident assessments are ongoing and care plans are revised as information about the resident and their condition changes. The facility's policy regarding behaviors, dated January 31, 2024, indicated that interventions and approaches would be based on a detailed assessment of physical, psychological and behavioral symptoms and their underlying causes, as well as the potential situational and environmental reasons for the behavior. The care plan would include, as a minimum, a description of behavioral symptoms, targeted and individualized interventions for the behavioral and/or psychosocial symptoms, the rationale for the interventions and approaches, specific and measurable goals for targeted behaviors, and how staff would monitor for effectiveness of the interventions. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 1, dated January 23, 2024, indicated that the resident was usually understood and could usually understand others, was cognitively intact, had no behaviors, and had diagnoses that included anxiety (feeling of fear, dread, and uneasiness). A care plan, dated October 16, 2023, revealed Resident 1 had behaviors and staff were to intervene as necessary to protect the rights and safety of others. A quarterly MDS assessment for Resident 4, dated February 24, 2024, revealed that the resident was understood, could understand others, exhibited physical behavioral symptoms directed towards others (e.g., hitting, kicking, pushing, scratching, grabbing, abusing others sexually) and verbal behavioral symptoms directed towards others (e.g., threatening others, screaming at others, cursing at others), which occurred one to three days during the review period, and had diagnoses that included multiple sclerosis (MS - a chronic disease of the central nervous system) and cerebral vascular accident (CVA - commonly referred to as a stroke). A care plan for the resident, dated November 8, 2023, revealed that the resident has a potential to be verbally aggressive towards other residents regarding another resident being in his room and can be verbally abusive with staff, curses at staff when angry. A quarterly MDS assessment for Resident 6, dated March 14, 2024, revealed that the resident was understood, understands, and had a diagnosis which included Parkinson's, and post-traumatic stress disorder (PTSD - a disorder that develops in some people who have experienced a shocking, scary, or dangerous event). (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395661	A. Building B. Wing	03/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Casselman Healthcare and Rehabilitation Center	201 Hospital Drive Meyersdale, PA 15552

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A nursing note for Resident 4, dated February 12, 2024, revealed that the writer was notified by staff that the resident was involved in an altercation with another resident. The resident stated, I came around the corner of the dining room, and Resident 1 says, 'Here comes that damn (Resident 4's first name)', which I did not do anything, so why is he running his mouth. I accidentally bumped into his chair, and then he hit me, and it was with a fist. The resident's right eye sclera (the white of the eye) showed busted blood vessels, with no discoloration or inflammation noted. The resident stated that it is slightly tender to palpation. The residents were separated. The certified registered nurse practitioner (CRNP - a registered nurse (RN) who has advanced education and clinical training in a health care specialty area) was in the facility and assessed the resident. The resident had a small scleral abrasion (an area damaged by scraping or wearing away) of the right eye with surrounding subconjunctival hemorrhage (a broken blood vessel in the eye). A new order was received for erythromycin ointment (a topical antibiotic) three times per day for seven days. A nursing note for Resident 4, dated February 14, 2024, revealed that the writer spoke with the resident about his behaviors toward Resident 1 and reminded him that he cannot threaten to hit or hit another resident. The resident had been threatening Resident 1 and lifted his arm up to hit. He did not hit Resident 1. Informed him that his behavior could cause him to be sent to a different facility and they may not permit smoking. His reply at first was, I'm a (Resident 4's last name), I don't back down. Then he said, No, I like it here, I like you, I will behave. A nursing note for Resident 4, dated March 4, 2024, revealed that the resident got into a verbal altercation with Resident 3 over cigarettes. The resident wheeled over to Resident 3 calling him names and raised his fist. The licensed practical nurse got between the residents and removed Resident 4 from the dining room. A nursing note for Resident 4, dated March 6, 2024, revealed that Resident 6 stopped by nursing station to report that Resident 4 was cursing at him going up the hall calling him a Mother f***** and a son of a b****. The nurse said she would make note of it and speak to Resident 4 to please be kind. When she spoke to Resident 4, he denied he said anything to Resident 6. A nursing note for Resident 4, dated March 9, 2024, revealed that the resident does not recall saying to Resident 6 that he was going to kick his butt. He said he might have because he says a lot of things. The resident was encouraged to try to refrain from derogatory comments towards other people. A nursing note for Resident 6, dated March 9, 2024, revealed that the resident reported that Resident 4 passed him in the hallway and told him he was going to kick his butt. Resident 4 did not approach him and there was no contact. He said that they were former roommates, and he does not care for him. The resident was instructed to avoid Resident 4 and report any concerns. The resident verbalized understanding. However, there was no documented evidence that Resident 1's, 4's or 6's care plans were updated/revised to reflect individualized, specific care and services interventions were updated after the incidents with Resident 1 and Resident 4. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395661	A. Building B. Wing	03/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Casselman Healthcare and Rehabilitation Center	201 Hospital Drive Meyersdale, PA 15552

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with MDS Assessment Coordinator (responsible for developing care plans) on March 26, 2024, at 4:55 p.m. confirmed that Resident 1's, 4's and 6's care plans were not updated/revised to reflect individualized, specific care and services interventions after the incidents. A quarterly MDS assessment for Resident 2, dated January 19, 2024, revealed that the resident was understood, understands, and had a diagnosis which included depression and post-traumatic stress disorder (PTSD - a disorder that develops in some people who have experienced a shocking, scary, or dangerous event). A nursing note, dated March 2, 2024, at 6:24 p.m. revealed that Resident 2 was arguing with Resident 1 about her buying pizza and not having enough money for cigarettes and she replied, You eat four or five slices of that pizza! Resident 1 raised his hand to slap her but was stopped when the licensed practical nurse saw him and stopped him. The residents were separated and informed to keep away from each other. Interview with Resident 2 on March 26, 2024, at 10:43 a.m. revealed that Resident 1 has tried to hit her several times. She indicated that this occurs whenever they are out smoking or in the dining room and it has been going on for years. However, there was no documented evidence that Resident 1's or 2's care plans were updated/revised to reflect individualized, specific care and services interventions that would be implemented after the incident with Resident 1 and Resident 2. Interview with MDS Assessment Coordinator on March 26, 2024, at 4:55 p.m. confirmed that Resident 1's and 2's care plans were not updated/revised to reflect individualized, specific care and services interventions after the incidents. 28 Pa. Code 211.12(d)(5) Nursing Services.