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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395661 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 11/08/2024 |
| NAME OF PROVIDER OR SUPPLIER Casselman Healthcare and Rehabilitation Center | | STREET ADDRESS, CITY, STATE, ZIP CODE 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.

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
| <p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>28177</p> <p>Based on clinical record reviews and staff interviews, it was determined that the facility failed to ensure that clinical records were complete and accurately documented for one one of six residents reviewed (Resident 5).</p> <p>Findings include:</p> <p>A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 5, dated October 4, 2024, revealed that the resident was understood; could understand others; had diagnoses that included anemia (low blood count), heart failure (a serious condition that occurs when the heart is unable to pump enough blood and oxygen to the body's organs), hypertension (high blood pressure), diabetes, cerebral vascular accident (CVA - commonly known as a stroke), and chronic obstructive pulmonary disease (COPD -a common lung disease that makes it difficult to breathe); and received oxygen therapy.</p> <p>A nursing note for Resident 5, dated November 2, 2024, at 2:00 a.m., and completed by Licensed Practical Nurse 1, revealed that at approximately 2:00 a.m. the writer went down to the second floor to change the resident's oxygen tubing. The resident had increased lethargy (a symptom that involves an unusual decrease in consciousness) and altered mental status (a change in how well the brain is working, which can lead to confusion, unusual behavior, or decreased alertness) along with rapid respirations and was diaphoretic (excessive sweating due to an underlying health condition or a medication). His oxygen tubing was replaced and was put on the resident. The Registered Nurse Supervisor on duty was made aware at this time. There was no documented evidence in Resident 5's clinical record to indicate that an assessment by a registered nurse was done at that time.</p> <p>Interview with Licensed Practical Nurse 1 on November 5, 2024, at 4:36 p.m. revealed that she was assigned the third floor. Around 2:00 a.m. she found out that the second floor licensed practical nurse had left, which she was not aware of, so she went down to the second floor to change to the oxygen tubing on the residents. She indicated that she got to Resident 5's room and noted a decline in his condition, so she notified the Assistant Director of Nursing, who was the Registered Nurse Supervisor on duty that night, and that he did go in and assess the resident at that time.</p> <p>Interview with the Nursing Home Administrator on November 5, 2024, at 4:25 p.m. confirmed that Resident 5's assessment by the Registered Nurse Supervisor on November 2, 2024, was not documented and should have been.</p> <p>(continued on next page)</p> |

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

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few | 28 Pa. Code 211.12(d)(1)(3)(5) Nursing Services. | | |