

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 04/01/2025
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.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p>19102</p> <p>Based on review of policies and clinical records, as well as observations and resident and staff interviews, it was determined that the facility failed to ensure that call bells were within reach for two of six residents reviewed (Residents 3, 5).</p> <p>Findings include:</p> <p>The facility's policy for call lights: accessibility and timely response, dated May 31, 2024, indicated that the purpose was to ensure the facility is adequately equipped with a call light at each residents' bedside, toilet, and bathing facility, to allow residents to call for assistance. Staff would ensure the call light was within reach of residents and secured, as needed.</p> <p>A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's care needs and abilities) for Resident 3, dated March 21, 2025, revealed that the resident could usually make herself understood and understand others, had moderate cognitive impairment, required assistance from staff for care needs, was occasionally incontinent of bladder, and had diagnoses that included seizures. A care plan for Resident 3, dated February 16, 2024, indicated that the resident was at risk for falls and the call bell was to be in reach.</p> <p>Observations of Resident 3 in her room on April 1, 2025, at 9:26 a.m. revealed that the resident was lying on her bed and her call bell was positioned on the wall above her bed and out of reach. When asked where her call bell was, she indicated that she did not know.</p> <p>Interview with Nurse Aide 1 on April 1, 2025, at 9:26 a.m. confirmed that Resident 3's call bell was out of her reach.</p> <p>A quarterly MDS assessment for Resident 5, dated March 24, 2025, revealed that the resident could make his needs known, had moderate cognitive impairment, required assistance from staff for care needs, was frequently incontinent of bowel and bladder, and had diagnoses that included kidney disease.</p> <p>A care plan for Resident 5, dated February 16, 2024, indicated that the resident required the assistance of one staff member with toileting and staff were to encourage the resident to use the call bell for assistance.</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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observations of Resident 5 in his room on April 1, 2025, at 9:50 a.m. revealed that the resident was asleep in his bed and his call bell was not seen on or near his bed. The call bell was lying on the floor near the bed closest to the door.</p> <p>Interview with Licensed Practical Nurse 2 on April 1, 2025, at 9:56 a.m. confirmed Resident 5's call bell was out of reach and that he did use his call bell.</p> <p>Interview with the Director of Nursing on April 1, 2025, at 1:16 p.m. confirmed that Resident 3's and 5's call bells should have been within their reach.</p> <p>28 Pa. Code 211.12(d)(1)(3)(5) Nursing Services.</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>19102</p> <p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>Based on review of facility policies and clinical records, as well as staff interviews, it was determined that the facility failed to provide care for pressure ulcers in accordance with professional standards of practice, by failing to ensure that recommendations from a wound consultant were reviewed with the attending physician for one of six residents reviewed (Resident 2) who had pressure ulcers.</p> <p>Findings include:</p> <p>The facility's policy regarding the prevention of pressure ulcers, dated May 31, 2024, indicated that the facility would review the resident's care plan and identify the risk factors as well as the interventions designed to reduce or eliminate those considered modifiable. The resident was to be assessed on admission for existing pressure injury risk factors, repeated weekly, and upon any changes in condition. The facility was to select appropriate support surfaces and pressure redistribution based on the resident's risk factors, in accordance with current clinical practice.</p> <p>A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 2, dated February 8, 2025, indicated that the resident had moderate cognitive impairment, was dependent on staff for care, had limited range of motion of the upper and lower extremities, had pressure ulcers (skin breakdown caused by pressure), and had diagnoses that included a stroke.</p> <p>A wound clinic note, dated January 17, 2025, revealed that Resident 2 had a Stage II pressure ulcer (partial thickness loss of dermis presenting as a shallow open ulcer with a red-pink wound bed, without slough or bruising) to the sacrum (lower part of the spine), a treatment of collagen particles (a type of medical dressing used to promote wound healing using purified collagen, a protein that is essential for skin and tissue repair) was being applied twice a day, and the area was improving without complications.</p> <p>A wound clinic note, dated January 24, 2025, revealed that Resident 2's pressure ulcer on the sacrum was worsening and was unstageable (not stageable due to coverage of the wound bed), and developed a new Stage II pressure ulcer on the left heel. It was recommended to change the treatment to the sacrum and apply medical grade honey (honey-based treatment that prevents infection and assists with healing) and calcium alginate (absorbent dressing) to the wound bed twice a day, and to consider an APP (alternating pressure pad using air) for offloading (reducing or redistributing pressure on specific areas of the body).</p> <p>A wound clinic note, dated January 31, 2025, revealed that Resident 2's pressure ulcer on the sacrum was stable and surgical debridement (medical procedure that involves removing dead, infected, or damaged tissue from a wound) of the wound was completed. It was again recommended to consider an APP for offloading.</p> <p>There was no documented evidence that the alternating pressure pad was discussed with the physician or put into place following the recommendations of the wound clinic on January 24 and 31, 2025.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A wound clinic note, dated February 7, 2025, revealed that Resident 2's pressure ulcer on the sacrum was stable. It was recommended to change the treatment to the sacrum and apply Dakin's Solution (used to prevent and treat skin and tissue infections) to the wound twice a day, consider an APP for offloading, and to obtain a sacral x-ray to determine the depth of the evolving sacral ulcer. A nursing note, dated February 7, 2025, at 1:23 p.m. revealed that an air mattress was being looked into for treatment.</p> <p>An x-ray result, dated February 8, 2025, revealed that the resident had osteomyelitis (a bone infection that occurs when bacteria or other microorganisms invade and infect the bone tissue) of the sacrum and was transferred to the hospital for further treatment.</p> <p>Interview with the Nursing Home Administrator and Director of Nursing on April 1, 2025, at 4:16 p.m. revealed that they thought APP was something staff physically put under the resident to alternate pressure but were not sure what APP was.</p> <p>Interview with Certified Registered Nurse Practitioner 3 on April 1, 2025, at 4:37 p.m. confirmed that she wanted and alternating pressure pad on the bed that had the air pump at the foot of the bed.</p> <p>28 Pa. Code 211.12(d)(1)(3)(5) Nursing Services.</p>		