

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  395682	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/13/2024
NAME OF PROVIDER OR SUPPLIER  Providence Health & Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE  900 Third Ave Beaver Falls, PA 15010	

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 0569</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Notify each resident of certain balances and convey resident funds upon discharge, eviction, or death.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41984</b></p> <p>Based on review of facility policy, closed clinical records, resident fund account statements and staff interview it was determined that the facility failed to convey resident funds in accordance with State law and closed accounts upon death in a timely manner for one of four closed resident records (Closed Resident Records CR1).</p> <p>Findings include:</p> <p>The facility Admission Assessment policy dated last reviewed 6/1/24, indicated that available funds in the account will be distributed within 60 days of death.</p> <p>Review of Closed Resident Records CR1's admission record indicated she was admitted on [DATE], with diagnoses that included congestive heart failure, gastro-esophageal reflux disease, and constipation.</p> <p>Review of Closed Resident Records CR1's MDS assessment (Minimum Data Set--MDS assessment: a periodic assessment of resident care needs) dated 4/26/24, indicated that the diagnoses were the most recent upon review.</p> <p>Review of Closed Resident Records CR1's nurse progress notes dated 5/12/24, indicated that staff was called to her room at 5:35 p.m. resident noted to have no spontaneous respirations, no auscultated or palpable heart rate, no palpated or auscultated heart rate, x 60 seconds, no response to verbal or tactile stimuli, resident has CTB, family aware, hospice notified.</p> <p>Review of resident account indicated that Closed Resident Records CR1 had a balance of \$8480.</p> <p>During an interview on 9/11/24, at 9:15 a.m. the Business Office Manager Employee E9 was asked about Closed Resident Records CR1's account and why it was still open It has to go to corporate for approval and that was new, in the position about 3 months.</p> <p>During an interview on 9/11/24, at 11:45 a.m. the Business Office Manager Employee E9 confirmed that the facility failed to convey resident funds in accordance with State law and closed accounts upon death in a timely manner as required.</p> <p>28 Pa. Code 211.5(d) Clinical records.</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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