

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395683	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/10/2024
NAME OF PROVIDER OR SUPPLIER Highlands Rehabilitation and Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 918 Main Street Laporte, PA 18626	

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 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 18229</p> <p>Based on clinical record review and staff interview, it was determined that the facility failed to protect a resident's right to be free from physical abuse for one of one resident reviewed for resident-to-resident interactions (Resident 1).</p> <p>Findings include:</p> <p>Clinical record review revealed the facility admitted Resident 1 on March 7, 2012, with diagnosis including unspecified dementia (a decline in mental ability that affects thinking, memory, and behavior, and interferes with daily life).</p> <p>Review of nursing documentation revealed a fall occurrence note dated November 30, 2024, at 4:37 PM indicating Resident 1 was noted to be on the floor next to her bed laying on her right side. Resident 1 was noted to be guarding her right arm and complaining of pain to her right arm. The fall was unwitnessed by staff. Resident 1's statement indicated Resident 1 reported her roommate (Resident 2) pushed me out of bed, and I'm scared.</p> <p>Nursing documentation dated December 1, 2024, at 1:22 PM revealed the facility received Resident 1's x-ray result, noting a mild fracture of the proximal humeral neck.</p> <p>Review of radiology results report dated December 1, 2024, confirmed a fracture of Resident 1's proximal right humeral neck.</p> <p>Clinical record review revealed the facility admitted Resident 2 on August 18, 2016, with diagnoses including bipolar disorder (a mental illness that causes extreme shifts in mood, energy, and activity levels). Review of Resident 2's most recent MDS (Minimum Data Set, an assessment completed at specific intervals to determine care needs) dated September 9, 2024, noted staff assessed Resident 2 with a BIMS (brief interview for mental status) summary score of 15 (a score of 13-15 indicates that a resident's cognition is intact).</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 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident 2's clinical record revealed nursing documentation dated November 30, 2024, at 5:30 PM indicating Employee 1 (registered nurse) was called to Resident 2's room because Resident 1 was noted to be on the floor. Employee 1 noted when Resident 2 was seen by staff in the hallway, she turned around and walked away from the room. Resident 2 denied knowing what happened to her roommate (Resident 1). Nursing documentation revealed for safety reasons Resident 2 was moved to a room on a different floor. Documentation revealed the state police arrived at the facility at 5:04 PM and spoke with Resident 2. Employee 1 noted Resident 2 reported to the police that she pushed her roommate out of bed and that she was going through some things. The facility placed Resident 2 on every 15-minute checks for safety.</p> <p>Review of the event reported to the Department of Health through the event reporting system on December 1, 2024, revealed there was a suspicion that Resident 2 pushed Resident 1 out of bed. Staff found Resident 1 lying on the right side of her bed on her right arm. Resident 2 was observed leaving her room from the hallway while staff were completing rounds. Staff immediately took Resident 2 out of the room when she returned to ensure the safety of Resident 1. To ensure the safety of all residents, the immediate intervention was to remove Resident 2 from the room and move her from the third floor to a semi-private room on the second floor. Further review of the event report revealed that the police were onsite to speak to Resident 2 and she admitted to the trooper that she pushed Resident 1 off her bed.</p> <p>Interview with Employee 1 (registered nurse) on December 10, 2024, at 12:58 PM revealed that she assessed Resident 1 after falling out of bed. Employee 1 confirmed that Resident 1 does not have a history of falling out of bed. She stated that Resident 2 had been acting differently recently due to the death another resident that she was close to.</p> <p>Review of the facility investigation dated November 30, 2024, revealed a witness statement from Employee 2 (nurse aide) noting when sitting 1:1 with Resident 2 she stated, I pushed her, I know it was wrong. Review of a witness statement from Employee 3 (nurse aide) revealed that Resident 2 told her that her room was moved because she pulled her roommate out of her bed. The facility investigation included every 15-minute checks starting on November 30, 2024, at 4:00 PM and ending on December 9, 2024, at 10:30 PM.</p> <p>Review of Resident 2's clinical record revealed that there were no other incidents of aggressive behavior toward staff or residents.</p> <p>Attempts to interview Resident 1 on December 10, 2024, were unsuccessful due to her cognitive status. Interview with Resident 2 on December 10, 2024, at 12:38 PM revealed that Resident 2 admitted to hitting Resident 1 and getting her room moved. Resident 2 stated she did not like Resident 1. Resident 2 attempted to change the subject several times during the conversation stating, I don't remember. Observation of Resident 2 at this time revealed that she is in a semiprivate room with Resident 3. Resident 2 complained to the surveyor that Resident 3 keeps her up all night and she doesn't like being in this room.</p> <p>Clinical record review for Resident 3 revealed an MDS dated [DATE], noting staff assessed Resident 3 as requiring extensive assistance of two staff for transfers. Interview with Resident 3 on December 10, 2024, at 12:44 PM, revealed she does not get out of bed often. Resident 3 stated that she requires a lift with two staff for all transfers.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview with the Director of Nursing on December 10, 2024, at 3:02 PM revealed that Resident 2 is attention seeking, and initially denied pushing Resident 1 out of bed. The Director of Nursing stated he was unsure if Resident 2 was looking for attention when she admitted to pushing Resident 1 out of bed.</p> <p>These findings were reviewed in a meeting with the Director of Nursing on December 10, 2024, at 3:04 PM.</p> <p>The facility failed to protect Resident 1's right to be free from physical abuse by another resident.</p> <p>28 Pa. Code 201.14 (a) Responsibility of licensee</p> <p>28 Pa. Code 201.18 (b)(1)(2)(e)(1) Management</p> <p>28 Pa. Code 201.29 (a)(c) Resident rights</p> <p>28 Pa. Code 211.12(c)(d)(1)(5) Nursing services</p>		