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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                             | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>395684 | (X2) MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing                             | (X3) DATE SURVEY COMPLETED<br><br>07/12/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Concordia Lutheran Health and Human Care |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>134 Marwood Road<br>Cabot, PA 16023 |  |

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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| <p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> | <p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 46336</p> <p>Based on review of facility policy, clinical records, facility documents, and staff interviews, it was determined that the facility failed to make certain each resident received adequate supervision that resulted in an elopement (resident exits to an unsupervised or unauthorized area without the facility's knowledge) for one resident. This failure created an immediate jeopardy situation for one of eight residents who were identified as at risk for elopement (Resident R1).</p> <p>Findings include:</p> <p>Review of the facility policy Incidents and Accidents dated 1/16/24, indicated an incident is an occurrence or situation that is not consistent with the routine care of a resident or with the routine operation of the organization. Incident and accidents requiring an incident/accident report include an elopement.</p> <p>Review of the facility policy Elopements and wandering Residents dated 1/16/24, indicated the facility ensures that residents who exhibit wandering behavior and/or are at risk for elopement receive adequate supervision to prevent accidents, and receive care in accordance with their person-centered plan of care addressing the unique factors contributing to wandering or elopement risk. Alarms are not a replacement for necessary supervision. Staff are vigilant in responding to alarms in a timely manner. Adequate supervision will be provided to help prevent accidents or elopements.</p> <p>Review of Communication Form dated 6/27/24, indicated please be alert to an alarm sounding (fire alarm, door alarm, wander guard alarm). Do not assume that someone else is checking on it. If an alarm is going off, immediately respond and notify others to complete a head count to check residents.</p> <p>Review of the admission record indicated Resident R1 was admitted to the facility on [DATE].</p> <p>Review of Resident R1's Minimum Data Set (MDS- a periodic assessment of care needs) dated 4/30/24, indicated the diagnoses of Dementia (a general term for loss of memory, language, problem solving and other thinking abilities that are severe enough to interfere with daily life) with agitation (a symptom of dementia includes verbal and physical aggression, restlessness, and pacing), difficulty walking, reduced mobility, wandering (traveling aimlessly from place to place), depression, high blood pressure, and anxiety (intense, excessive, and persistent worry and fear about everyday situations). Section C indicated a Brief Interview for Mental Status (BIMS - is a screening test that aides in detecting cognitive impairment) as a score of 5 - severe impairment.</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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| <p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>               | <p>Review of Resident R1's current physician orders on 7/9/24, indicated check skin integrity under wanderguard (a bracelet that sets an alarm if resident passes through) left lower extremity every shift. Check function weekly.</p> <p>Review of Resident R1's care plan dated 3/26/24, indicated risk for wandering/elopement identified. Goal is the resident's safety will be maintained. Intervention to clearly identify resident's room and bathroom. Provide structured activities: toileting, walking inside and outside, reorientation strategies including signs, pictures and memory boxes. Wander alert bracelet.</p> <p>Review of Resident R1's Kardex dated 7/9/24, indicated limited assistance of one staff for transfers and toileting. The Kardex failed to have wander alarm checked off.</p> <p>Review of Resident R1's Progress notes indicate escalation of wandering, resisting care, agitation, confusion, and anxiety on seven occasions from 6/13/24 - 6/26/24, prior to the elopement and accident event on 6/26/24.</p> <p>-On 6/13/24, at 3:24 p.m. Registered Nurse (RN) Employee E1's progress note indicated staff found resident on the floor in the [NAME] Hall kitchenette area. Staff assisted resident back into her wheelchair, resident aggressive towards staff members, kicking staff. Writer re-approached resident and medicated with as needed Ativan (anxiety medication) for behaviors, completed ROM (range of motion) exercises to all four extremities.</p> <p>-On 6/14/24 at 10:20 a.m. Certified Registered Nurse Practitioner (CRNP) Employee E2's Provider Note indicated Chief Complaint fall, skin tear - resident does have some cognitive impairment noted related to dementia with behavioral disturbance, continue Ativan PRN and added 0.5mg (milligrams) routinely as well for increased anxiety and agitation. Continue Seroquel (antipsychotic medication) 50mg twice daily due to increased behaviors. Consider increasing this to three times a day if behaviors continue.</p> <p>-On 6/15/24, at 4:32 a.m. Licensed Practical Nurse (LPN) Employee E3's progress note indicated resident self-transferred into another resident's room this shift and staff assisted with resident transfer back into her own bed.</p> <p>-On 6/16/24, at 7:11 p.m. RN Employee E4's progress note indicated resident is very aggressive with staff. Going into resident's rooms and breaking their personal items. Resident self-transferring throughout the shift and in the hallway. Resident is very mean and uncooperative with all care. Attempting to hit and bite staff members. Fire doors were shut and resident was banging on those and screaming to get out. Resident finally went to sleep after many episodes of bad behavior. Resident needs a stronger medication from the doctor to combat these outbursts.</p> <p>-On 6/17/24, at 3:22 p.m. Physician Employee E5's Provider Note indicated Chief Complaint aggression, going in others' rooms. Patient has had aggressive behaviors. The behaviors are frequently happening in the evening.</p> <p>On 6/26/24, 12:00 a.m. LPN Employee E6's elopement evaluation indicated:</p> <p>-History of elopement while at home - Yes</p> <p>(continued on next page)</p> |  |  |

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| <p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> | <p>-Wandering behavior a pattern or goal-directed - Yes</p> <p>-Wanders aimlessly or non-goal directed - Yes</p> <p>-Wandering behavior likely to affect the safety or well-being of self/others - Yes</p> <p>-Wandering behavior likely to affect the privacy of others - Yes</p> <p>-Recently admitted or readmitted and has not accepted the situation - No.</p> <p>On 6/26/24, at 9:56 p.m. LPN Employee E7's SBAR (Situation, Background, Assessment, Recommendation Form) Event indicated a nurse aide notified writer that resident was observed in the stairwell. Writer observed resident sitting in wheelchair at the bottom of 10 steps. Resident stated that her and the wheelchair fell down the first flight of stairs. Resident exited to the steps through a locked fire door. Alarm did not sound. Resident last seen 45 minutes prior in the dining room by nurse aide. Pain score five out of ten being highest. Physician notified at 8:00 p.m. Recommendation maintain wander guard on resident. Physician order to send to emergency department due to resident stating her face, head, and neck hurt.</p> <p>Review of facility provided Unwitnessed fall document dated 6/26/24, at 9:36 p.m. indicated Nurse Aide (NA) notified writer (LPN Employee E7) that resident was observed in the stairwell by the nurse on the other unit. Writer observed resident sitting in a wheelchair at the bottom of 10 steps with the wheelchair facing up the steps. Resident stated that her and the wheelchair rolled down the first flight of stairs. Resident exited to the steps through a locked fire door. Per staff the alarm did not sound throughout the event. Resident indicated she had to get out to feed her dog. She opened the door and rolled her wheelchair down the stairs. She stated she hit her head off the wall.</p> <p>Review of facility provided documentation indicated LPN Employee E24's witness statement dated 6/27/24, at 10:38 a.m. indicated I heard over the walkie (two way radio) staff needed assistance in the Blank Stairwell. RN Employee E1 followed me over where RN Employee E27 and LPN Employee E12 were assessing Resident R1 amazingly in her wheelchair. Assessing vitals seems like baseline. How we going to get her out of the stairwell? We decided to go down to the first floor. Not sure how she got in stairwell assuming door would have alarmed.</p> <p>Review of the Emergency Hospital visit document dated 6/26/24, indicated Staff states they saw the door open and found patient sitting at the bottom of steps in her wheelchair.</p> <p>Review of LPN Employee E7's statement dated 6/27/24, at 12:53 p.m. indicated Who saw resident last? NA Employee E25 saw Resident R1 forty-five minutes prior in the dining room, unsure who saw her in stairwell, just that LPN Employee E12 got a call saying she was there. NA Employee E28 I think, said she saw her going down the hall with a tray on her lap. I just reported to the call over the walkie she was sitting in her chair at bottom of steps. I did not hear any alarms go off leading up to incident.</p> <p>(continued on next page)</p> |

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| <p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>               | <p>Review of NA Employee E25's statement dated 6/27/24, at 2:27 p.m., indicated NA Employee E26 was walking down the hall asking has anyone seen Resident R1? Maybe around 8:00 p.m. though she was on the rehab unit as she used to have a room over there. RN Employee E27 going to check locked doors, utility rooms, I was at the end of hallway and heard over walkie stairwell NA Employee E28 said found in stairwell. Opened the door and saw her. She was at the fish tank earlier. Went to stairwell, four or five staff were there assisting resident so didn't assist. She was on first landing she had her dinner tray at top of landing by ladder, she had flowers on the tray, we didn't hear any beeping. Two women always leave out that door after dinner, but I didn't see them that day.</p> <p>Review of LPN Employee E19's statement dated 6/27/24, at 3:47 p.m. indicated LPN Employee E7 on the [NAME] unit said she couldn't find Resident R1, maybe around 8:00 p.m. Aides started looking someone went to the stairwell to look, and said they found her. I did not hear any alarms.</p> <p>Music Therapy Employee E31's statement indicated on 6/26/24, at 5:30 p.m. and 6:30 p.m. was conducting music activities in the lounge and saw Resident R1 at 5:30 p.m. in dining room and Resident R1 did not attend evening activity that day.</p> <p>Review of NA Employee E28's statement dated 6/27/24, at 4:08 p.m. indicated she last saw her coming down hall between 7:00 p.m. and 8:00 p.m., unsure of exact time, she had a tray with flowers on it. She usually goes to back of the Blank unit and sits there, not all the time but sometimes came out of room after helping serve didn't see her. They said over walkie they were looking for her. They found Resident R1 in stairwell. Think it was 8:15 p.m. She was in stairwell sitting facing towards steps, black marks on tile at bottom of steps like chair had skidded. No blood, no bruising said her lip hurt, said she hit lip. Tray was at top of steps tried to ask her, but she couldn't tell us. Initially looked like she was sweating a little under the eyes. She didn't say anything hurt. Once we opened the door the alarm went off.</p> <p>Review of NA Employee E30's statement dated 6/27/24, at 5:16 p.m. indicated went to find Resident R1 around 8:30 p.m. or 9:00 p.m. to see if she wanted to go to bed. Went to the dining room where I last saw her at 7:30 p.m. and started walking rooms, went to rehab, went over walking and said anyone else see her. Someone saw her in the staircase, down the steps sitting in the wheelchair. Said she was trying to feed her dog. She has a stuffed Dalmatian in her room. She complained of her neck and head hurting. No alarm heard when an unidentified Priest was trying to go through exit earlier in the day. Did not see visitor use stairwell on the Blank unit.</p> <p>Observation on 7/9/24, at 9:58 a.m. NA Employee E8 reset the alarm to the elevator. There were no residents present in the area. NA indicated she didn't see anybody, so she turned it off. Indicated it meant that someone with a wander bracelet got close to the elevator. A head count was not initiated as required.</p> <p>Interview on 7/9/24, at 9:59 a.m. the Nursing Home Administrator confirmed that a head count should be initiated and directed staff to do so.</p> <p>Observation on 7/9/24, at 10:01 a.m. Resident R1 was not in her room, her wheelchair was in room and was empty. Resident noted to be in her bathroom alone, despite instructions on the Kardex to use limited assist of one for transfers and toileting.</p> <p>(continued on next page)</p> |  |  |

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| <p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>               | <p>Interview on 7/9/24, at 11:39 a.m. Housekeeping Employee E18 indicated I'm supposed to keep an eye on them (wandering residents). I know who they are just from being here. If they are too close to the door I'll bring them back or if I need help I get help. No searches since I've been here. I think they have fake drills probably on other shifts. I've never been here for a fake drill.</p> <p>Interview on 7/9/24, at 11:41 a.m. RN Employee E19 indicated We have wander guards. There are codes at the exits and elevators and you place a code to make them stop.</p> <p>Interview on 7/9/24, at 1:09 p.m. NA Employee E20 indicated It depends who it is. Like one resident wanders and we try to guide her back to the [NAME] Unit because they know her better. For Resident R1, the [NAME] Unit keeps their eyes out. The codes were posted at doorways and now are taken down.</p> <p>Interview on 7/9/24, at 1:28 p.m. NA Employee E21 indicated We try to give them puzzles keep their minds occupied. Sometimes I'll take someone to the balcony to get some fresh air. Usually two of us NA's will switch on and off while a resident is active.</p> <p>Interview on 7/9/24, at 1:30 p.m. NA Employee E22 indicated We share when there's an active resident we are worried about. The bracelet will set off an alarm at the elevator and if we can't see what happened then we walkie talkie for a head count and we shut off the alarm.</p> <p>Interview on 7/9/24, at 1:33 p.m. RN Employee E23 indicated, I work evenings sometimes, around 9:00 p.m. people are being put to bed and showers are being done. She had a wanderguard on stairwell doesn't alarm from bracelet just elevators. Switch off with us keep them behind the desk with us or place in the living room (area referred to as the Lobby).</p> <p>Interview on 7/9/24, at 1:36 p.m. RN Employee E19 indicated I was here training the day Resident R1 went down the stairs, I was on Blank Unit and the [NAME] Unit called and said they were missing a resident. We started looking in rooms bathrooms, closets, hallways, and one of the nurses found her in the stairwell. That's all I know. My trainer went to help and I continued on task.</p> <p>Telephonic interview on 7/11/24, at 9:31 a.m. NA Employee E25 indicated I saw her down by the music room one of our NA's had to leave around 7:00 p.m. or 7:15pm because of something personal, at the time we had to switch assignments, I can't remember how many we were running with that day. I think we started with nine and ended up with eight after she left that day. I went and spoke to my other co-worker and asked are we switching groups or what? Can someone tell me what's going on. I was a little stressed because now I have residents that I didn't have before and had to ask can you tell me what's been done with the residents, showers, changed, etc. I was going room to room around 7:30 p.m. I had four residents still in the four season room and Resident R1 was not in the 4-seasons room at that time. They asked have you seen Resident R1? I said, the last time I had her she would sit on Rehab at the nurses desk. We're going to start looking behind locked doors and I was on Blank Unit. I hear stairwell over the walkie. Two people were going down to the stairwell. Usually, the door is locked so I was confused. I told them I don't know if they are workers or visitors but there are two older ladies that go down that stairwell after dinner time usually an alarm goes off. Maybe the door doesn't shut all the way? I don't know how to work the doors. Maybe it popped back open. Resident R1 was sitting in her chair on the landing. She was on the right side of the landing. The chair looked normal. Honestly, everyone was in shock that she was not bleeding, and the chair was intact.</p> <p>(continued on next page)</p> |  |  |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>395684   | (X2) MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing                             | (X3) DATE SURVEY COMPLETED<br><br>07/12/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Concordia Lutheran Health and Human Care   |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>134 Marwood Road<br>Cabot, PA 16023 |  |
| 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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)  |  |  |
| <p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>               | <ol style="list-style-type: none"> <li>1. Resident R1 was evaluated at the hospital on 6/26/24, and suffered no injury related to unwitnessed fall.</li> <li>2. Resident R1's care plan was updated to reflect wandering behaviors and ensure supervision and monitoring are in place.</li> <li>3. All residents will be evaluated with the elopement risk assessment to ensure wandering/elopement behaviors were identified and care planned as needed and reflect adequate supervision and monitoring. This will be completed through the Electronic Health Record Behavior Monitoring.</li> <li>4. The elopement policy remains unchanged. New steps implemented were verified of codes to doors removed and door alarm audits initiated. Facility obtained quotes to install wander guard system to all second-floor exit doors.</li> <li>5. Ad Hoc QAPI (Safety Meeting) including the DON, Medical Director, Administrator, Therapy, Social Services, and Human Resources was conducted on 7/1/24.</li> <li>6. Education on the elopement policy and procedure, wander guard system was initiated on 6/27/24 by DON/designee.</li> <li>7. A new education will be initiated 7/11/24, to educate on elopement policy, wandering identification and steps to take once risk is identified, education includes process once risk is identified, if resident is actively exit seeking or have any of the signs of elopement risk (ambulate independently or mobile, history of elopement, or attempted elopement, verbal expression of desire to go home, packing belongings to go home, staying near and exit door wandering, wandering pattern with specific destination in mind, wandering aimlessly or non-goal directed, wandering behavior that is likely to affect the safety or well-being of self or others, wandering behavior likely to affect the privacy of others, recently admitted and not accepting of the situation, staff will initiate every 15 minutes checks and ensure wander guard is in place until the interdisciplinary team meet. An Email to the Activities Department to update the elopement risk program posting, then activities will distribute to all units and departments. Education will be completed by 7/12/24, at 11:00 a.m.</li> <li>8. All staff were previously educated annually, and upon hire on the facility elopement policy as of 6/27/24.</li> <li>9. All staff will be educated on recognizing signs and symptoms of resident elopement before the start of their next shift with follow-up to ensure understanding and compliance. To be completed by 11:00 a.m. on 7/12/24.</li> <li>10. Monitoring - all residents identified as exit seeking/wandering will be audited by the DON/Designee for elopement monitoring, supervision, and interventions daily by five days, twice a week by four weeks, and then weekly by one month. Results of the reviews will be submitted to the facility Quality Assurance and Process Improvement Committee for review and development of an action plan as needed.</li> </ol> <p>Review of facility documentation on 7/12/24, it was verified the following interventions were completed:</p> <p>(continued on next page)</p> |  |  |

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| <p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>               | <p>1. Resident R1 was evaluated at the hospital on 6/26/24 and suffered no injury related to unwitnessed fall.</p> <p>2. Resident R1's care plan was updated to reflect wandering behaviors and ensure supervision and monitoring are in place.</p> <p>3. All residents were evaluated to ensure wandering/elopement behaviors were identified and care planned as needed and reflected adequate supervision and monitoring. This was completed through the Electronic Health Record Behavior Monitoring.</p> <p>4. The elopement policy remains unchanged. New steps implemented were verified of codes to doors removed and door alarm audits initiated. Facility obtained quotes to install wander guard system to all second- floor exit doors.</p> <p>5. Ad Hoc QAPI (Safety Meeting) including the DON, Medical Director, Administrator, Therapy, Social Services, and Human Resources was conducted on 7/1/24.</p> <p>6. Education on the elopement policy and procedure, wander guard system was completed on 7/11/24.</p> <p>7. All staff were educated on recognizing signs and symptoms of resident elopement policy and procedure and wander guard system, steps to take once risk is identified, the process once risk is identified if resident is actively exit seeking staff will initiate q 15 minute checks. Activities will be emailed to update the elopement risk program posting, then activities distributes to all units, before the start of the next shift and follow up was conducted to ensure understanding and compliance by 11:00 a.m. on 7/12/24.</p> <p>8. All residents identified as exit seeking wandering will be audited by the DON/designee for elopement monitoring, supervision and interventions with audit tool created.</p> <p>9. Survey Agency (SA) confirmed 311/312 staff were educated as stated above with a competency post-test. All staff in house on daylight (71 all departments) were interviewed and verified they had training and did not have any questions.</p> <p>The Immediate Jeopardy was lifted on 7/12/24, at 2:00 p.m. when the action plan implementation was verified.</p> <p>Interview on 7/12/24, at 2:00 p.m. the Nursing Home Administrator confirmed that the facility failed to provide adequate supervision for Resident R1 which resulted in an elopement. This failure created an immediate jeopardy situation for one of eight residents who were identified as high risk for elopement.</p> <p>28 Pa. Code 201.14(a) Responsibility of Licensee.</p> <p>28 Pa. Code: 201.20 (a)(c) Staff development.</p> <p>28 Pa. Code 201.29(a)(c)(d)(j) Resident Rights.</p> <p>28 Pa. Code 211.10(c)(d) Resident Care Policies.</p> <p>(continued on next page)</p> |  |  |

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| <p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> | <p>28 Pa. Code: 211.12 (d)(1)(3)(5) Nursing Services.</p>   |

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| <p>F 0835</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>Administer the facility in a manner that enables it to use its resources effectively and efficiently.</p> <p>46336</p> <p>Based on review of job descriptions, clinical records, and staff interviews, it was determined that the Nursing Home Administrator and Director of Nursing did not effectively manage the facility to make certain that necessary care and services were provided to residents requiring adequate supervision to prevent elopement.</p> <p>Findings include:</p> <p>Review of CFR S483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.</p> <p>Based on the findings in this report that identified that the facility failed to maintain necessary supervision to prevent elopement which resulted in one resident being found at the bottom of ten stairs in a wheelchair after elopement and placed seven other residents in an Immediate Jeopardy. Facility failed to provide fundamental principal that applies to treatment and care provided to facility residents. The facility failed to ensure that residents receive treatment and care in accordance with professional standards of practice, facility policies, physician orders, and the comprehensive person- centered policy.</p> <p>28 Pa Code: 201.14 (a) Responsibility of licensee.</p> <p>28 Pa Code: 201.18 (b)(1) Management.</p> |  |  |