STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395702	A. Building B. Wing	05/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beacon Ridge	1515 Wayne Avenue Indiana, PA 15701

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41233 Based on review of facility policies, as well as observations and staff interviews, it was determined that the facility failed to provide a clean and homelike environment in residents' rooms for five of 38 residents reviewed (Resident 1, 13, 25, 29, 75). Findings include: The facility's policy regarding homelike environment, dated January 2, 2025, indicated that the facility staff and management were to the extent possible maximize the characteristics of the facility that reflect a personalized homelike setting including a clean, sanitary, and orderly environment. Observations of Resident 1's room on May 22, 2025, at 9:10 a.m. revealed that there was a large area of dried chipping paint, approximately 24 inches by 10 inches above the heating/cooling unit. Interview with the Maintenance Director on May 22, 2025, at 9:40 a.m. revealed that he was not aware of the chipping paint and indicated that with all the rain lately that moisture must be coming in the walls. An annual Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 13, dated December 2, 2024, indicated that the resident was cognitively intact, was understood and able to understand others, was independent for care needs, and had diagnoses that included anxiety and manic depression. An admission MDS assessment for Resident 29, dated December 18, 2024, indicated that the resident was cognitively intact, was understood and able to understand others, required supervision to moderate assistance for care needs, and had diagnoses that included orthostatic hypotension (low blood pressure with changes in body position) and diabetes mellitus. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observations of Resident 13 and 29's room [ROOM NUMBER] on May 19, 2025, at 11:20 a.m. revealed that there was an area of broken dry wall, approximately 18 inches by 18 inches, near the packaged terminal air conditioner (PTAC - a self-contained through-the-wall heating and air conditioning unit). There was also a resident blanket rolled up sitting on the window sill and the wall was starting to bubble under the paint on either side of the window. In the corner of the window was a three-inch line of a black/grey, removable substance. The wall trim below the wall was pulling away from the wall and in some areas lying on the floor. The window sill was loose and breaking apart in the corner. Interview with Residents 13 and 29 at the time of the observations revealed that they put a blanket on the windowsill to block out the cold draft. A little bit ago some of the pieces of the wall fell on the floor, and maintenance staff cleaned it up, and said they would be back to clean it up. However they have not returned to fix anything. Observations of Resident 13 and 29's room on May 22, 2025, at 9:52 a.m. revealed the PTAC and window conditions were the same and the blanket was now wet. Interview with Resident 29 at the time of the observations indicated no staff have come in to fix the area. Interview with Maintenance Director on May 22, 2025, at 11:23 a.m. revealed that maintenance concerns from nursing are communicated with paper slips that are picked up daily. He confirmed that the areas of dry wall were in need of repair, water was coming in through the window causing water damage to the windowsill making it loose and breaking apart, the paint and wall trim had water damage, there was a black, removable substance on the corner of the window, and that the areas were not homelike. There was no work order that he was aware of in the system, and he was not aware this room needed such repairs. He also indicated that the flashing above the window may be a concern, which allows water to come in behind the stucco. Observations of Resident 25's room on May 22, 2025, at 9:21 a.m. revealed that there was an area of broken out drywall, approximately seven inches by seven inches on the wall below the window next to the floor. Observations of Resident 75's room on May 22, 2025, at 9:30 a.m. revealed that there was an area of dried visibly chipping paint, approximately 12 inches by 10 inches above the heating/cooling unit. Interview with the Maintenance Director on May 22, 2025, at 9:52 a.m. revealed that he was not aware of the chipping paint in rooms [ROOM NUMBERS], or the broken drywall in Resident 75's room. He indicated that it was unacceptable and that his staff would be correcting the concerns. 28 Pa. Code 207.2(a) Administrator's Responsibility.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 43856 Based on review of facility policy and clinical records, as well as staff interviews, it was determined that the facility failed to ensure that a care plan was created to reflect the resident's specific care needs for one of 38 residents reviewed (Resident 7). Finding include: A facility policy, dated January 2, 2025, revealed that a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. It will aid in preventing or reducing decline in the resident's functional status and/or functional levels and assessments of residents are ongoing and care plans are revised as information about the residents and the resident's conditions change. An annual Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 7, dated, May 5, 2025, revealed that the resident was cognitively intact, required assistance with daily care needs, and had a diagnosis of Parkinson's disease. Clinical record review for Resident 7 revealed that there was no documented evidence that a care plan was created to address specific care needs related to Parkinson's disease. Interview with the Nursing Home Administrator on May 21, 2025, at 10:48 a.m. confirmed that Resident 7 did not have a care plan developed to address her specific care needs related to Parkinson's disease, and it should have been. 28 Pa. Code 201.24(e)(4) Admission Policy. 28 Pa. Code 211.12(d)(5) Nursing Services.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 42079 Based on review of facility policies and clinical records, as well as staff interviews, it was determined that the facility failed to ensure that care plans were updated/revised to reflect a resident's specific care needs for three of 38 residents reviewed (Residents 35, 47, 50). Findings include: A facility policy regarding comprehensive person-centered care plans, dated January 2, 2025, indicated that comprehensive, person-centered care plans are developed within seven days of the completion of the required comprehensive Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs). Assessments of residents are ongoing, and care plans are revised as information about the residents and the resident's conditions change. A quarterly MDS assessment for Resident 35, dated February 26, 2025, indicated that the resident was cognitively intact, required assistance with care needs, and had a diagnosis of hypertension (high blood pressure). A care plan for Resident 35, dated September 16, 2024, indicated that the resident was receiving a diuretic (a medication used to treat fluid retention and hypertension) related to edema (fluid retention in body tissues) and hypertension. Review of Resident 35's clinical record, including review of the resident's Medication Administration Record (MAR), revealed no documented evidence that the resident was receiving a diuretic. Interview with the Nursing Home Administrator on May 21, 2025, at 2:02 p.m. confirmed that Resident 35's care plan should have been revised to reflect that he was not receiving a diuretic. A quarterly MDS assessment for Resident 47, dated March 1, 2025, indicated that the resident was cognitively intact, was understood, usually understands, was independent with care needs, and had a diagnoses of dementia, anxiety, depression, and bipolar disease (shifts in mood, energy, and activity levels, encompassing both periods of manic and depression). A care plan for Resident 47, dated March 3, 2023, indicated that the resident was an elopement risk and a wanderer with impaired safety awareness. The care plan included an intervention to have a code alert bracelet at all times numbered 9000-0434J with an expiration date of April 21, 2024. Physician orders for Resident 47, dated March 22, 2025, included an order to have code alert bracelet on at all times numbered 9000-0434M with expiration date October 25, 2025, and checked for placement every shift. Observations of Resident 47 on May 21, 2025, at 11:11 a.m. revealed that the resident was lying in bed. Licensed Practical Nurse 1 checked the alert bracelet and it was labeled 9000-0434M with an expiration date of October 25, 2025. Interview with the Nursing Home Administrator on May 21, 2025, at 2:01 p.m. confirmed that Resident 47's care plan should have been revised to reflect the correct code alert bracelet information. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An annual MDS assessment for Resident 50, dated May 7, 2025, indicated that the resident was cognitively impaired, was usually able to make herself understood and was usually able to understand others, and required assistance with care needs. A care plan for Resident 50, dated February 17, 2025, indicated that the resident had a urinary tract infection with an intervention that included to give antibiotic therapy as ordered. Review of Resident 50's clinical record, including review of the resident's Medication Administration Record (MAR), revealed no documented evidence that the resident had a urinary tract infection and no documented evidence that she was receiving an antibiotic. Interview with the Nursing Home Administrator on May 22, 2025, at 10:11 a.m. indicated that she believed Resident 50's care plan should have stayed in effect related to her MDS. 28 Pa. Code 211.12(d)(5) Nursing Services.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 43856 Based on a review of clinical records, as well as resident and staff interviews, it was determined that the facility failed to safely transfer one of 38 residents reviewed (Resident 62) who required assistance from staff for transfers. Findings include: An admission minimum data set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 62, dated March 4, 2025, indicated that he was alert and oriented, required moderate assistance for daily care needs, and assist of one for transfers with wheeled walker and gait belt. Observations of Resident 62 on May 22, 2025, at 8:24 a.m. revealed that Nurse Aide 2 transferred the resident from a seated position to his wheelchair by using the back of his pants while there was a gait belt on the back of his wheelchair. Interview with Nurse Aide 2 on May 22, 2025, at 8:26 a.m. revealed that she was aware of Resident 62's transfer status and that she did not use a gait belt for the transfer instead she used the back of his pants for the transfer. Interview with Nursing Home Administrator on May 22, 2025, at 2:08 p.m. confirmed that Resident 62 should have been transferred with the use of a gait belt and he was not. 28 Pa. Code 211.12(d)(5) Nursing Services.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 41233 Based on review of facility policies and clinical records, as well as observations and staff interviews, it was determined that the facility failed to ensure that residents received proper care for indwelling urinary catheters (a flexible catheter used to drain urine from the bladder into a drainage collection bag) for three of 38 residents reviewed who had an indwelling urinary catheter (Residents 4, 7, 10). Findings include: The facility's policy regarding urinary catheter care, dated January 2, 2025, indicated that staff are to be sure the catheter tubing and drainage bag are kept off the floor. An annual Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 4, dated May 7, 2025, revealed that the resident was severely cognitively impaired, required assistance with daily care, had an indwelling urinary catheter, and had a diagnosis of neuromuscular dysfunction of the bladder (nerve damage to the bladder). A care plan for Resident 4, dated March 19, 2023, revealed that the resident had an indwelling urinary catheter and staff were to ensure that the drainage bag was off the floor and below the level of the bladder. Observations of Resident 4 on May 21, 2025, at 10:32 a.m. revealed that the resident was sitting in her broda chair (customized wheelchair) in the Bayside lounge. Nurse Aide 3 entered the lounge and transported the resident approximately 18-20 feet back to her room to brush her hair prior to the resident's beautician appointment. Her indwelling urinary catheter drainage bag was connected underneath her wheelchair, as the resident was being transported, approximately four inches of the bottom of the dignity bag drug across the floor. Interview with the Director of Nursing, Infection Preventionist, and Nurse Aide 3 on May 21, 2025, at 10:35 a.m. confirmed that Resident 4's indwelling urinary catheter dignity bag should not have been in direct contact with the floor. All three staff remarked that it is a challenge to keep the dignity bags off the floor due to some of the chairs being so low to the floor. An annual MDS assessment for Resident 7, dated, May 5, 2025, revealed that the resident was cognitively intact, required assistance with daily care needs, and had an indwelling urinary catheter (a soft flexible tube inserted into the bladder to drain urine), Physician's orders for Resident 7, dated April 29, 2025, included an order for the indwelling catheter to be changed every 30 days. Review of Resident 7's Treatment Administration Record (TAR) for May 2025 revealed no documented evidence that the catheter change for May 5, 2025, was completed. Interview with the Nursing Home Administrator on May 21, 2025, at 10:41 a.m. confirmed that there was no documented evidence that Resident 7's indwelling catheter was changed every 30 days as ordered on May 5, 2025, and it should have been. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A quarterly MDS assessment for Resident 10, dated March 2, 2025, revealed that the resident was cognitively intact, required assistance with care needs, had an indwelling urinary catheter, and had a diagnosis of obstructive uropathy (blockage of the urinary tract). A care plan for Resident 10, dated March 16, 2022, revealed that the resident had an indwelling urinary catheter, and staff were to ensure that the drainage bag was off the floor, below bladder level, and that the tubing was secured to avoid pulling or trauma. Physician's orders for Resident 10, dated November 11, 2024, included an order for staff to check the resident's catheter bag and tubing every shift for proper positioning (below bladder level and off the floor) and cover for dignity. Observations of Resident 10 on May 19, 2025, at 11:34 a.m. revealed that the resident was sitting in her wheelchair in her room. Her indwelling urinary catheter drainage bag was connected underneath her wheelchair with the dignity bag half on and half off with part of the drainage bag exposed. The indwelling urinary catheter tubing was lying in direct contact with the floor. During an interview with Licensed Practical Nurse 4 on May 19, 2025, at 11:46 a.m., Resident 10 proceeded to wheel herself towards this writer and the nurse, dragging the indwelling urinary catheter tubing on the floor. The nurse indicated that she knew the catheter bag had to be off the floor and that her concern with the catheter tubing being on the floor was that the resident may step on it. Interview with the Nursing Home Administrator on May 19, 2025, at 3:15 p.m. confirmed that Resident 10's indwelling urinary catheter tubing should not have been in direct contact with the floor. 28 Pa. Code 211.12(d)(3)(5) Nursing Services.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 48941 Based on review of facility policies and clinical records, as well as staff interviews, it was determined that the facility failed to maintain accountability for controlled medications (drugs with the potential to be abused) for one of 38 residents reviewed (Resident 35). Findings include: A facility policy regarding medication administration, dated January 2, 2025, indicated that the individual administering the medication initials the resident's Medication Administration Record (MAR) on the appropriate line after giving each medication and before administering the next ones. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 35, dated February 26, 2025, indicated that the resident was cognitively intact, required assistance with care needs, and was taking an opioid medication (medications with the potential to be abused used to treat pain). Physician's orders for Resident 35, dated January 30, 2025, included an order for the resident to receive 5-325 milligrams (mg) of Hydrocodone-Acetaminophen (a narcotic pain medication) every six hours as needed for pain. Review of the controlled drug record (a form that accounts for each tablet/pill/dose of a controlled drug) for Resident 35, dated February, March, April and May 2025, revealed that a 5-325 mg tablet of Hydrocodone-Acetaminophen was signed out on February 22 at 10:00 p.m.; February 23 at 5:30 a.m. and 9:00 p.m.; March 8 at 9:00 p.m.; March 9 at 8:30 a.m.; March 10 at 3:15 a.m.; March 20 at 9:06 p.m.; March 22 at 9:00 p.m.; March 23 at 6:00 a.m.; March 23 at 9:00 p.m.; March 24 at 6:00 a.m.; March 30 at 8:47 p.m.; April 9 at 6:00 a.m.; April 10 at 9:00 p.m.; April 11 at 6:00 a.m.; April 11 at 9:51 p.m.; April 22 at 6:00 a.m.; May 10 at 9:34 p.m.; and May 11 at 9:26 p.m. However, there was no documented evidence in Resident 35's clinical record, including the MAR, that the signed-out doses of Hydrocodone-Acetaminophen were administered to the resident on the above-mentioned dates and times. Interview with the Director of Nursing on May 21, 2025, at 1:38 p.m. confirmed that there was no documented evidence in Resident 35's clinical record to indicate that the signed-out doses of Hydrocodone-Acetaminophen were administered to the resident on the above-mentioned dates and times. 28 Pa. Code 211.9(a)(1) Pharmacy Services. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing Services.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41233 Based on review of facility policies, manufacturer's instructions, and clinical records, as well as observations and staff interviews, it was determined that the facility failed to maintain a medication error rate of less than five percent. Findings include: A facility policy regarding medication administration, dated January 2, 2025, indicated that medications are administered in accordance with prescriber orders, including any required time frame. The individual administering the medication checks the label three times to verify the right resident, right medication, right dosage, right time, and right method (route) of administration before giving the medication. Each nurses' station has a current Physician's Desk Reference (PDR) and/or other medication reference available. Observations during medication administration on May 21, 2025, revealed that three medication administration errors were made during 29 opportunities for error, resulting in a medication administration error rate of 10.34 percent. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 32, dated May 6, 2025, indicated that the resident was cognitively impaired, required assistance from staff for care needs, and had diagnoses that included hypertension (high blood pressure). Physician's orders for Resident 32, dated March 30, 2023, included an order for the resident to receive 25 milligrams (mg) of Metoprolol Succinate ER (Extended-Release) tablet daily related to hypertension. Observations of medication administration on May 21, 2025, at 8:16 a.m. revealed that Licensed Practical Nurse 1 crushed the extended-release tablet of Metoprolol Succinate prior to administering the medication to Resident 32. Interview with Licensed Practical Nurse 1 on May 21, 2025, at 9:50 a.m. confirmed that she should not have crushed Resident 32's extended-release tablet of Metoprolol Succinate. A quarterly MDS assessment for Resident 55, dated April 4, 2025, indicated that the resident was cognitively impaired, required assistance from staff for care needs, and had diagnoses that included obstructive uropathy (blockage of the urinary tract) and benign prostatic hyperplasia (enlarged prostate). Physician's orders for Resident 55, dated December 5, 2023, included an order for the resident to be administered a 0.4 mg capsule of Tamsulosin HCL daily related to benign prostatic hyperplasia. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observations of medication administration on May 21, 2025, at 7:48 a.m. revealed that Licensed Practical Nurse 5 removed the contents of the Tamsulosin HCL capsule, placed the contents in applesauce, and administered the medication to Resident 55. Manufacturer's instructions for Tamsulosin HCL indicated that the capsules should not be crushed, chewed or opened. Interview with Licensed Practical Nurse 5 on May 21, 2025, at 9:44 a.m. confirmed that she removed the contents of the Tamsulosin HCL capsule prior to administering the medication to Resident 55 and that she was not aware that the medication should not be removed from the capsule. An admission note for Resident 129, dated May 20, 2025, indicated that the resident had diagnoses that included heart disease and presence of right artificial hip joint. Physician's orders revealed that the resident was admitted to the facility on [DATE], with an order for aspirin 325 milligrams (mg) give one tablet daily for blood clot prevention related to right artificial hip joint. Observations of medication administration on May 21, 2025, at 8:24 a.m. revealed that Licensed Practical Nurse 6 administered aspirin 81 mg instead of the ordered dose of 325 mg. Interview with Licensed Practical Nurse 6 on May 21, 2025, at 11:25 a.m. confirmed that she administered aspirin 81 mg instead of the physician ordered dose of 325 mg. Interview with the Nursing Home Administrator on May 21, 2025, at 3:35 p.m. confirmed that Resident 32's metoprolol succinate extended-release table should not have been crushed, that the contents of the Tamsulosin HCL capsule should not have been removed prior to administering the medication to Resident 55, and that Resident 129 should not have received aspirin 81 mg, but rather the correct physician-ordered dose of aspirin 325 mg. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing Services.

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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)
F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 41233 Based on review of the facility's plans of correction for previous surveys, and the results of the current survey, it was determined that the facility's Quality Assurance Performance Improvement (QAPI) committee failed to correct quality deficiencies and ensure that plans to improve the delivery of care and services effectively addressed recurring deficiencies. Findings include: The facility's deficiencies and plans of corrections for State Survey and Certification (Department of Health) survey ending June 6, 2024, revealed that the facility developed plans of correction that included quality assurance systems to ensure that the facility maintained compliance with cited nursing home regulations. The results of the current survey, ending May 22, 2025, identified repeated deficiencies regarding safety and accident hazards, failure to provide proper catheter care, and failure to ensure the accountability of controlled substances. The facility's plan of correction for a deficiency regarding safety and accident hazards, cited during the survey ending June 6, 2024, revealed that the facility would complete audits and report the results of the audits to the QAPI committee for review. The results of the current survey, cited under F689, revealed that the facility's QAPI committee failed to successfully implement their plan to ensure ongoing compliance with regulations regarding safety and accident hazards. The facility's plan of correction for a deficiency regarding a failure to provide proper catheter care, cited during the survey ending June 6, 2024, revealed that the facility would complete audits and the results would be reviewed as part of quality assurance. The results of the current survey, cited under F690, revealed that the facility's QAPI committee was ineffective in maintaining compliance with the regulation regarding catheter care. The facility's plan of corrections for deficiencies regarding accountability of controlled substances, cited during the survey ending June 6, 2024, revealed that the facility would complete audits and report the results of the audits to the QAPI committee for review. The results of the current survey, cited under F755, revealed that the facility's QAPI committee failed to successfully implement their plan to ensure ongoing compliance with regulations regarding accountability of controlled substances. Refer to F689, F690 and F755. 28 Pa. Code 201.14(a) Responsibility of Licensee. 28 Pa. Code 201.18(e)(1) Management.