

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  395705	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/29/2024
NAME OF PROVIDER OR SUPPLIER  Hempfield Manor		STREET ADDRESS, CITY, STATE, ZIP CODE  1118 Woodward Drive Greensburg, PA 15601	

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 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 39311</p> <p>Based on review of select facility documents, clinical record review as well as resident and staff interviews, it was determined that the facility failed to ensure sufficient staffing to meet resident need for one of three residents (Resident R1).</p> <p>Findings include:</p> <p>Review of the facility, Nursing Services Policy dated 12/8/23, indicated the facility will have sufficient nursing staff to provide nursing and related services to attain or maintain the highest physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care.</p> <p>Review of the clinical record indicated Resident R1 was admitted to the facility on [DATE].</p> <p>Review of the Minimum Data Set (MDS - periodic assessment of care needs) dated 3/27/24, included the diagnoses of chronic obstructive pulmonary disease (COPD - a group of progressive lung disorders characterized by increasing breathlessness), chronic respiratory failure with hypoxia (inadequate respiration resulting in low levels of oxygen in the blood), and the need for assistance with personal care. Review of Section O: Special Treatments and Programs revealed the use of oxygen therapy.</p> <p>During an interview on 4/21/24, beginning at 11:37 a.m. the family member of Resident R1 stated, her mother [Resident R1] had called her the evening of 4/3/24, ad stated that she was having a hard time breathing, and was still waiting to get into bed. Family member stated that she call the facility and spoke to the Assistant Director of Nursing, and was told that there had been an incident that night with her mother. Family member stated that she was told that her mother was in her chair without oxygen and her sats (level of oxygen saturation) were pretty low and that she was put on a concentrator and either is wasn't working or they didn't catch it.</p> <p>Review of an employee statement written by NA Employee E1, dated 4/3/24, revealed Me and [NA Employee E2] got on shift around 4:15 p.m. and started answering lights and changing people. I was in with a different resident, and [NA Employee E2] came in and said she went to check on Resident R2 and it's a different resident there, that it was a was [Resident R1] and she was having a hard time breathing. That someone had her on her portable oxygen had her portable was on zero, instead of the concentrator. [NA Employee E2] said she let the nurse know when they checked her oxygen and got her on the concentrator C-hall was going wild that night.</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 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of an Administration Follow-up with NA Employee E1 on 4/9/24: She could not verify time, but knows. It knows it was around dinner and first rounds. (Both nurse aides came in late to do rounds later). Believes it was between 5:00 - 6:00 p.m. that they went into room and saw oxygen issue. NA Employee E2 in first and got NA Employee E1. They got her on room concentrator. Asked about delay in answering Room Resident R1's call light (6:47 p.m. to 7:34 p.m.) stated she knows they were super busy, everyone's lights were on (told the NHA, Nursing Home Administrator to check whole C-hall light report). Does not recall resident having any issue with oxygen after that time on room concentrator.</p> <p>Review of an employee statement written by NA Employee E2, dated 4/3/24, revealed I want to check on Resident R2 because she hadn't rang at all since I been there which is not like her. I made it to the room I seen the new resident [Resident R1] sitting there panicking about her oxygen/ I then checked her tank because it was a portable one on her wheelchair and it was empty. I went to get a pulse ox (pulse oximeter, instrument to measure oxygen in the blood) to check her oxygen level and she was a 70%. Then I went to go get a nurse and connected her to a concentrator, which, by the way, was placed in the room but never connected. Nor was I informed she was there or needed to be connected. C-hall was going wild that night.</p> <p>Review of an Administration Follow-up with nurse on 4/9/24: Nurse aide stated she cannot remember exact time. Resident was found in the above statement, but that it was during dinner hour 5:30 p.m. to 6:00 p.m. as trays were being passed. When asked about delay and answering call light 6:47 p.m. to 7:34 p.m., nurse aide admitted that C-hall was extremely hectic and that the nurse aides were trying to get to all call lights timely, but that resident's oxygen was fine at that time. No more issues with that she would have remembered.</p> <p>During an interview on 4/29/24, at 12:30 p.m. NA Employee E2 stated that due to her school schedule, she does not get to work until 4:00 p.m., and no staff informed her that there had been a change of residents in the room. Stated, The hall was a mess. There was just me and NA Employee E1 on the hall. I went into the room and Resident R1 was gasping for air, saying Oh, I can ' t breathe. I took her oxygen and it was like in the 60's. I hooked her up to the concentrator. There wasn't even a nurse on the hall at that point, I had to go across the hall and found Licensed Practical Nurse (LPN) Employee E4. NA Employee E2 stated that after she had had gotten Resident R1 back into bed, she found and told Registered Nurse Employee E3 about Resident R1 being without oxygen. I don't remember her checking on (Resident R1). When asked about the delay in call lights, NA Employee E2 stated that the facility does not have enough staff.</p> <p>Review of an employee statement dated 4/3/24, written by RN Employee E3 On 4/3/24, I was a med nurse on C-hall. This nurse, and both (nurse aides) were never told that she had been moved to C- hall already. I was passing meds prior to dinner when the nurse aide informed me that [Resident R1] was on the hall and portable oxygen was empty. and she connected her to the oxygen concentrator in which case she came up to 92 - 96% via nasal canula.</p> <p>Review of an Administration Follow-up with RN Employee E3 on 4/9/24: Verbal follow-up on 4/8/24. RN cannot verify exact time she was notified of oxygen being out, but believes it was between 5-6:00 p.m. as she was passing evening meds. RN did not chart.</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 4/29/24, at 1:15 p.m. RN Employee E3 confirmed the information in her provided statement and additionally stated, It was a crazy, crazy night. One thing after another. There is a high acuity on C-hall. When asked why she did not document in the clinical record Resident R1 being without oxygen, RN Employee E3 stated that she was too busy that night.</p> <p>Review of Resident R1's progress notes failed to reveal any notes related to her oxygen running out.</p> <p>Review of facility provided investigative documents regarding the investigation of 7/3/24, evening shift incident. The investigation confirmed the room change completed on this date. The 3-11 staff on hall (med nurse and two aides) all wrote statements confirming that on 4/3/24, evening resident was found in her room on the e-tank (portable oxygen tank) with no more oxygen left in the tank. Resident was immediately switched to the oxygen room concentrator. Her sats were low from not being on oxygen, but did go back up to 92% when oxygen applied. All three staff members cannot verify exact time this occurred, but all three state it was during dinner time as dinner meds were being given and dinner trays were being passed (between 5:00 - 6:00 p.m.). There was no charting in the medical record regarding this.</p> <p>This investigation further documented, The call bell log from resident's room shows she turned her light on at 6:47 p.m. and it was not turned off until 7:30 p.m. Upon further interviewing with the aides, they stated there was no further oxygen issues after the earlier one with the e-tank, and that they were having difficulty answering the call lights in a timely manner due to it being busy. The call bell log from that hall during 6:30 p. m. to 7:30 p.m. revealed 11 call lights going off.</p> <p>During an interview on 4/29/24, at approximately 2:00 p.m. the Nursing Home Administrator confirmed that the facility failed to ensure sufficient staffing to meet resident need for one of three residents.</p> <p>28 Pa. Code 201.14(a) Responsibility of licensee.</p> <p>28 Pa. Code 211.12(d)(1)(3)(5) Nursing services.</p>		