Printed: 08/01/2024
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395731	A. Building B. Wing	04/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bethel Park Skilled Nursing and Rehabilitation Ctr	60 Highland Road Bethel Park, PA 15102

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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49646 Based on review of facility policy, clinical record reviews and interviews with staff, it was determined that the facility failed to establish a baseline care plan within 48 hours of admission/readmission for three of five residents (Resident R301, R307 and R312). Findings include: A review of facility policy Person Centered Care Plan reviewed 1/18/24, indicated it is the policy of this facility to develop and implement a baseline person-centered care plan for each resident within 48 hours of admission/readmission that will include the instructions needed to provide effective and person-centered care that meet professional standards of quality care. A review of the clinical record indicated Resident R301 was admitted to the facility on [DATE], with diagnoses that included diabetes (a long-term condition in which the body has trouble controlling blood sugar and using it for energy), high blood pressure and colon cancer. A review of the Minimum Data Set (MDS- a periodic assessment of care needs) dated 4/21/24, indicated the diagnoses remained current. Review of Resident R301 nurse progress notes indicated he arrived with a colostomy (creates an opening for the colon through the abdomen so that stool can be emptied) in place and documentation regarding Present, Stoma (opening in the body) Within normal limits on 4/20/24, and Present on 4/22/24 and 4/24/24. Review of Resident R301's care plan failed to provide a baseline plan of care for the colostomy. A review of the clinical record indicated Resident R307 was admitted to the facility on [DATE], with diagnoses that included high blood pressure, obstructive and reflux uropathy (urine cannot drain through the urinary tract) and fracture of right lower leg. A review of the MDS dated [DATE], indicated the diagnoses remained current. Review of Resident R307 nurse progress notes indicated a catheter (tube that goes into the bladder to allow urine to drain) in place as noted on the following dates: 4/10/24, 4/15/24 and 4/24/24. (continued on next page)

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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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident R307's care plan failed to provide a baseline care plan for catheter care within the forty-eight-hour timeframe. A review of the clinical record indicated Resident R312 was admitted to the facility on [DATE], with diagnoses that included high blood pressure, diabetes, and panlobular emphysema (permanent damage that causes obstruction, making it difficult to breathe). A review of the MDS dated [DATE], indicated the diagnoses remained current. Review of Resident R312 nurse progress notes indicated the resident arrived on oxygen via a nasal cannula (device used to deliver supplemental oxygen or increased airflow via the nose) as noted on the following dates: 4/11/24, 4/15/24 and 4/25/24. Review of Resident R312's care plan failed to provide a baseline care plan for supplemental oxygen requirement via nasal cannula within the forty-eight-hour timeframe. During an interview on 4/25/24, at 10:18 a.m. the Director of Nursing confirmed Residents R301, R307 and R312 baseline care plan was not initiated to reflect the resident's current status within forty-eight hours of admission. 28 Pa. Code 211.11(d) Resident care plans. 28 Pa. Code: 211.12(d)(1)(5) Nursing services.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39311 Based on review of clinical records, observations, and staff interview, it was determined that the facility failed to provide prescribed treatment and services related to the care of pressure ulcers for three of five residents (Resident R22, R76, and R85). Findings include: The facility policy Skin Integrity and Wound Management dated 1/18/24, indicated that an initial and ongoing nurse assessment of intrinsic and extrinsic factors that influence skin health, wound impairment, and the ability of the wound to heal will be performed. Complete a comprehensive evaluation of the resident upon admission and identify the resident's skin integrity status. During the course of the survey, observations of residents with wound orders were completed as follows: Observation 1: 4/23/24, beginning at approximately 11:30 a.m. Observation 2: 4/24/24, beginning at approximately 9:30 a.m. Observation 3: 4/24/24, beginning at approximately 12:00 p.m. Observation 4: 4/24/24, beginning at approximately 2:30 p.m. Observation 5: 4/24/24, beginning at approximately 10:00 a.m. Observation 6: 4/24/24, beginning at approximately 12:05 p.m. Observation 7: 4/24/24, beginning at approximately 1:05 p.m. Observation 8: 4/24/24, beginning at approximately 3:15 p.m. Review of the clinical record indicated Resident R22 was admitted to the facility on [DATE]. Review of the Minimum Data Set (MDS - periodic assessment of care needs) dated 3/15/24, included the diagnoses of coronary artery disease (damage or disease in the heart's major blood vessels), hemiplegia (paralysis on one side of the body), and history of a stroke. Review of Section GG: Functional Abilities and Goals indicated that Resident R22 had range of motion impairments of one upper and one lower extremity. Review of Section M: Skin Conditions, indicated Resident R22 was at risk of pressure ulcer development. Review of Resident R22's Braden Scale Assessment (a tool utilized to assess a patient's risk of developing a pressure ulcer) dated 3/8/24, revealed Resident R76 was at high risk for the development of pressure ulcers. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of a physician order dated 3/16/23, indicated for Resident R22 to be assisted to turn and reposition Q2 hour (every two hours). Review of Resident R22 plan of care for Risk for Alteration in Skin Integrity initiated 5/31/13, revised on 11/7/17, included the goal of Turn and reposition as patient tolerates, Q2 hours and prn (as needed) with assist of one. Review of the nurse aide Kardex (paper or electronic document that outlines the patients' activities of daily living - ADLs, continence levels, and behaviors, as well as physician, advanced directives, diet, and allergies) for Resident R22 indicated for staff to Turn and reposition as patient tolerates, Q2 hours and prn with assist of one. Review of Resident R22's wound report documentation for dated 3/7/24, revealed that an initial evaluation was completed to evaluate bilateral buttock wounds. Wound #1 Left Buttock is a Deep Tissue Pressure Injury (A pressure-related injury to subcutaneous tissues under intact skin). Initial wound encounter measurements are 3 cm length x 4 cm. Wound #2 Right Buttock is a Stage 2 Pressure Ulcer (partial-thickness skin loss with exposed middle layer of skin) and has received a status of Not Healed. Initial wound encounter measurements are 6 cm length x 3.5cm width x 0.1 cm depth. The periwound skin (skin around the outer edges of the wound) was denuded (loss of the top layer of skin). Review of Resident R22's wound report documentation dated 3/21/24, indicated Wound #1 Stage 2 Pressure Ulcer, 2cm x 1cm x 0.1 cm. Wound #2 Right Buttock is a Stage 2 Pressure Ulcer 5cm length x 5cm width x 0. 1 cm depth. The periwound skin was denuded. Review of Resident R22's wound report documentation dated 4/4/24, indicated Wound #1 noted as resolved. Wound #2 Right Buttock is a Stage 2 Pressure Ulcer 6.5cm length x 5cm width x 0.1 cm depth. The periwound skin was denuded. Wound noted as deteriorated. Review of Resident R22's wound report documentation dated 4/11/24, indicated Wound #1 Reopened Stage 2 Pressure Ulcer, 1cm x 2. 5cm x 0.1 cm. Wound noted as deteriorated Wound #2 Right Buttock is a Stage 2 Pressure Ulcer 6 cm x 3 cm x 0.1 cm. The periwound skin was denuded. No change in progression. Review of Resident R22's wound report documentation dated 4/18/24, indicated Wound #1 Reopened Stage 2 Pressure Ulcer, 1cm x 2. 5cm x 0.1 cm. Wound noted as deteriorated Wound #2 Right Buttock is a Stage 2 Pressure Ulcer 6 cm x 5cm x 0.1 cm. The periwound skin was denuded. Wound noted as deteriorated. During observations of Resident R22 the following was noted: Observation 1: sitting up in bed, positioned on back. Observation 2: sitting up in bed, positioned on back. Observation 3: sitting up in bed, positioned on back. Observation 4: sitting up in bed, positioned on back. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation 5: Receiving care. Observation 6: sitting up in bed, positioned on back, legs and ankles directly on pillow, not off loaded. Observation 7: sitting up in bed, positioned on back, legs and ankles directly on pillow, not off loaded. Observation 8: sitting up in bed, positioned on back. During an interview on 4/25/24, at approximately 5:20 p.m. the Nursing Home Administrator confirmed that Resident R22 had worsening pressure ulcers and that Resident R22 was not turned and repositioned appropriately during the above observations. Review of the clinical record indicated Resident R76 was admitted to the facility on [DATE]. Review of the MDS dated [DATE], included the diagnoses of dementia (a group of symptoms that affects memory, thinking and interferes with daily life) and traumatic brain injury. Review of Section GG: Functional Abilities and Goals indicated that Resident R76 had range of motion impairments of both upper and lower extremities. Review of Section M: Skin Conditions, indicated Resident R76 was at risk of pressure ulcer development, and had one Stage 3 pressure ulcer: full-thickness loss of skin, in which fat is visible in the ulcer and granulation tissue eschar (dry, dark scab or falling away of dead skin) and/or slough (dead tissue that needs to be removed for wound to heal) may be visible. Review of Resident R76's plan of care for Risk for Alteration in Skin Integrity initiated 5/30/18, included the goal of Turn and reposition as patient tolerates, Q2 hours and prn. Review of the nurse aide Kardex for Resident R76 indicated for staff to Turn and reposition as patient tolerates, Q2 hours and prn. Review of a progress note dated 4/1/24, at 1:03 p.m. indicated left malleolus, open area center has slough and foul odor. scant amount serosanguineous (clear liquid mixed with blood) drainage, tissue surrounding area reddened. Review of a progress note dated 4/2/24, at 12:29 p.m. indicated Resident R76 was found to have a new left lateral ankle wound, measuring 2.5 cm x 1.5 cm x 0.2 cm. Review of Resident R76's wound report documentation dated 4/4/24, indicated a new wound on the lateral aspect of the left ankle. According to the facility EMR (electronic medical record) the wound was found earlier this week. Patient is unable to provide any information regarding the wound. She does yell out in pain with cleaning of the wound. According to the notes there was slough and foul-smelling drainage initially. She was evaluated by the primary team nurse practitioner and recommended to have Therapy honey gel applied. Discussed with nursing. The wound assessment noted: Lateral Ankle is a Stage 4 Pressure Ulcer (full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer) and has received a status of Not Healed. Initial wound encounter measurements are 2cm length x 1. 5cm width x 0.5 cm depth. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the MDS dated [DATE], included the diagnoses of chronic obstructive pulmonary disease (COPD, a group of progressive lung disorders characterized by increasing breathlessness) and diabetes (a metabolic disorder in which the body has high sugar levels for prolonged periods of time). Review of Section GG: Functional Abilities and Goals indicated that Resident R85 had range of motion impairment of one upper extremity. Review of Section M: Skin Conditions, indicated Resident R85 was at risk of pressure ulcer development, and had two Stage II pressure ulcers. Review of the clinical record indicated Resident R85 was admitted with wounds to the left and right buttock. Review of the Braden Scale assessment dated [DATE], revealed Resident R85 was at high risk for the development of pressure ulcers. Review of Resident R85's plan of care for Risk for Alteration in Skin Integrity initiated 3/18/24, included the goal of encourage to turn and reposition. Review of the nurse aide Kardex for Resident R85 indicated for staff to Encourage and/or assist to reposition frequently and Turn and/or reposition. Further review failed to reveal the use of off-loading boots. Review of Resident R85's progress note dated 4/9/24, at 12:29 p.m. indicated Nursing reports new wound to left ankle order to cleanse left ankle with NS (normal saline), dry, apply Medihoney and border gauze every other day-will follow up with wound care. Review of Resident R85's wound report documentation dated 4/11/24, indicated Left Heel is a Deep Tissue Pressure Injury. Initial wound encounter measurements are 3. 5cm x 4 cm with no measurable depth. Under the Additional orders section of the report revealed Offload heels per facility protocol - Offloading boots. Review of Resident R85's wound report documentation dated 4/18/24, indicated Stage 3 Pressure Ulcer and has received a status of Not Healed. Subsequent wound encounter measurements are 3 cm x 4 cm x 0.1 cm. The wound is deteriorating. During observations of Resident R85 the following was noted: Observation 1: sitting up in bed, positioned on back, heels not off loaded, not wearing offloading boots. Observation 2: sitting up in bed, positioned on back, legs turned to side, not off loaded, not wearing offloading boots. Observation 3: sitting up in bed, positioned on back, legs crossed, not off loaded, not wearing offloading boots. Observation 4: sitting up in bed, positioned on back, legs crossed, not off loaded, not wearing offloading boots. Observation 5: Receiving care. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation 6: sitting up in bed, positioned on back, heels not off loaded, not wearing offloading boots. Observation 7: Receiving care. Observation 8: Seated in wheelchair, not wearing offloading boots. During an observation on 4/25/24, at approximately 3:20 p.m. failed to reveal offloading boots present in Resident R85 ' s room. Review of Resident R85's physician's orders failed to include an order for the use of offloading boots. During an interview on 4/25/24, at approximately 5:20 p.m. the Nursing Home Administrator confirmed that Resident R85 developed a facility acquired pressure ulcer and Resident R85 was not turned and repositioned appropriately during the above observations. During an interview on 4/25/24, at approximately 5:20 p.m. the Nursing Home Administrator confirmed the facility failed to provide prescribed treatment and services related to the care of pressure ulcers for three of five residents. 28 Pa. Code: 211.12(d)(1)(5) Nursing services.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39311 Based on review of facility policy, observations, and staff interview, it was determined that the facility failed to make certain that medications and medication supplies were properly stored and/or disposed of in one of three medication rooms (Second-floor medication room) and two of seven medication carts (Second-floor medication cart for rooms ,d+[DATE] and Second-floor medication cart for rooms ,d+[DATE]). Findings include: Review of the facility policy Storage and Expiration Dating of Medications, Biologicals dated [DATE], indicated: -Facility should ensure that all medications and biologicals, including treatment items, are securely stored in a locked cabinet/cart or locked medication room that is inaccessible by resident and visitors. -Facility should ensure that medications and biologicals that: (1) have an expired date on the label; (2) have been retained longer than recommended by manufacturer or supplier guidelines; or (3) have been contaminated or deteriorated, are stored separately from other medications until destroyed or returned to the pharmacy or supplier. -Facility staff may record the calculated expiration date based on the date opened on the pharmacy medication container. -If a multidose vial of an injectable medication has been opened or accessed (e.g., needle-punctured), the vial should be dated and discarded within 28 days unless the manufacturer specifies a different (shorter or longer) date for that open vile. -When an ophthalmic solution or suspension has a manufacturer shortened beyond use date once opened, facility staff should record the date opened and the date to expire on the container. During an observation on [DATE], at 11:00 a.m. of the Second-floor medication room, the following was observed: -Bottle of prescription barrier lotion for Resident R97, with a use-by date of [DATE]. -(2) vacutainers with an expiration date of [DATE]. -(16) vacutainers with an expiration date of [DATE]. During an interview on [DATE], at 11:25 a.m. RN Employee E1 confirmed that the medication for Resident R97 was still currently in use, and confirmed the vacutainers were expired. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on [DATE], at 11:20 a.m. the Second-floor medication cart (Rooms ,d+[DATE]) was noted to be unlocked, without nursing staff present in the hallway. Registered Nurse (RN) Employee E2 exited a room approximately three doors down on [DATE], at 11:24 a.m. During an interview on [DATE], at 11:25 a.m. RN Employee E2 confirmed that the medication cart had been left unsecured and without supervision by nursing staff. During an observation on [DATE], at 11:26 a.m. of the interior of the Second-floor medication cart (Rooms , d+[DATE]), revealed a vial of insulin for Resident R255, dated as opened on [DATE] on the box and also dated as opened on [DATE], on the vial. During an interview on [DATE], at 11:27 a.m. RN Employee E2 confirmed that the insulin had been dated incorrectly. During an observation on [DATE], at 3:15 p.m. of the interior of the Second-floor medication cart (Rooms , d+[DATE]), revealed the following: -vial of insulin for Resident R75, opened, partially used, and undated. -insulin injectable pen for Resident R7, opened, partially used, and undated. During an interview on [DATE], at 3:17 p.m. Licensed Practical Nurse Employee E3 confirmed the above undated items. During an interview on [DATE], at 5:20 p.m., the Nursing Home Administrator confirmed that the facility failed to make certain that medications and medication supplies were properly stored and/or disposed of in one of three medication rooms and two of seven medication carts. 28 Pa. Code: 201.14 (a) Responsibility of licensee. 28 Pa. Code: 201.18 (b)(1)(e)(1) Management. 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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39311 Based on facility policy, clinical record review, and staff interview, it was determined that the facility failed to make certain that a pneumococcal immunization was offered to two of five residents (Resident R101 and R119). Findings include: Review of the facility policy Pneumococcal Vaccination dated 1/18/24, indicated the facility will provide the opportunity to receive the appropriate pneumococcal vaccine to all patients/residents. The policy further stated the facility will offer the PCV20 (pneumococcal conjugate) vaccine to adults 19-[AGE] years of age with underlying medical conditions. Review of the Centers for Disease Control (CDC) document, Pneumococcal Vaccination: Summary of Who and When to Vaccinate last reviewed 1/24/22, indicated that CDC recommends pneumococcal vaccination for all adults [AGE] years or older, and for adults 19 through [AGE] years old who have certain chronic medical conditions or other risk factors. Included in this list were: alcoholism, chronic liver disease, chronic lung disease, chronic renal failure, cigarette smoking, diabetes, and heart failure. Review of the Admission Record indicated that Resident R101 was admitted to the facility on [DATE]. Review of Minimum Data Set (MDS-periodic assessment of care needs) dated 3/28/24, included diagnoses of a chronic osteomyelitis (inflammation of bone or bone marrow, usually due to infection), high blood pressure, and chronic kidney disease (gradual loss of kidney function). Section O0300 Pneumococcal Vaccine indicated Resident R101 was not offered the pneumonia vaccine. Review of the clinical record failed to include documentation of education provided to Resident R101 and/or their representative of the risks and benefits of the pneumonia vaccination. Review of the Admission Record indicated that Resident R119 was admitted to the facility on [DATE]. At the time of the survey, Resident R119 was less than [AGE] years old. Review of MDS dated [DATE], included diagnoses of a coronary artery disease (damage or disease in the heart's major blood vessels), hemiplegia (paralysis on one side of the body), and history of a stroke. Section O0300 Pneumococcal Vaccine indicated Resident R101 was not offered the pneumonia vaccine. Review of the clinical record failed to include documentation of Resident R119 being offered the pneumonia vaccination. During an interview on 4/25/24, at 5:20 p.m. the Nursing Home Administrator confirmed that the facility failed to make certain that a pneumococcal immunization was offered to two of five residents. 28 Pa. Code 211.5(f) Clinical records.