

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395732	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/15/2024
NAME OF PROVIDER OR SUPPLIER Heritage Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 5701 Phillips Avenue Pittsburgh, PA 15217	

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 - 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** 46167</p> <p>Based on review of facility documents, facility policy, clinical records, resident interview, and staff interviews, it was determined that the facility failed to provide appropriate goods and services to prevent falls, resulting in neglect for one of two residents (Resident R1), which resulted in actual harm of a dislocated shoulder for Resident R1.</p> <p>Findings include:</p> <p>Review of facility policy Abuse and Neglect- Clinical Protocol, review date undetermined, indicated that neglect is defined as the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress.</p> <p>Review of the facility job description for Certified Nursing Assistant, indicated that the purpose of the job position is to provide each resident with routine daily nursing care and services in accordance with the resident's assessment and care plan and as may be directed by your supervisor in accordance with the requirements of the policies and procedures of this facility in accordance with current federal, state, and local standards governing the facility. Job duties include assisting with lifting, turning, moving, positioning, and transporting residents into and out of beds, chairs, bathtubs, wheelchairs, lifts, etc.</p> <p>Review of Resident R1's admission record indicated she was admitted to the facility on [DATE].</p> <p>Review of Resident R1's Minimum Data Set (MDS) assessment (mandated assessment of a resident's abilities and care needs) dated 6/17/24, indicated diagnoses Vitamin C deficiency, and generalized edema (fluid accumulation that affects the whole body).</p> <p>Review of Resident R1's admission record indicated additional diagnoses of muscle wasting and atrophy (decrease in size).</p> <p>Review of Resident R1's Physical Therapy evaluation dated 7/22/24, indicated that resident requires maximum assistance of two people with a mechanical lift (Hoyer- a device used to safely lift a person with minimal physical effort) for transfers form one surface to another.</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 - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident R1's progress note dated 7/30/24, at 10:42 p.m. revealed; Resident left facility via stretcher by 911 (non-emergent) to hospital for trauma to left bicep. Safety maintained.</p> <p>Review of a written witness statement dated 7/31/24, from NA Employee E1 stated: Resident R1 was in the shower room on shower chair. NA Employee E2 asked me if I can assist her with putting resident in wheelchair. We stood resident up in shower at bar. Once she (Resident R1) stood she said her legs was 'giving out'. We tried to reach for wheelchair but it was too far so we lower her to the floor.</p> <p>Review of documentation provided by the facility dated 8/1/24, stated the following: Resident R1 was admitted to the facility on [DATE]. On 7/29/24 the resident was given a shower and as two nurse aides stood her to dress her in the shower room by standing her up at grab bar. Resident R1's legs gave out and she was assisted to the ground resulting in a fall. Description of Follow-up Action: The resident was immediately assessed by the registered nurse, and she was lifted off the floor. Vital signs were at baseline. No bruising or injuries noted. Doctor and POA (power of attorney- a person who is legally named to act on someone else's behalf) notified. Fall protocol initiated. Increased pain was found in the left arm over the next day. CRNP (Certified Registered Nurse Practitioner) notified of increased pain and came to assess the resident. CRNP gave orders for the resident to be sent out to the ER (emergency room) for possible trauma to the left bicep. On 7/31/24 it was founded that Resident R1's left shoulder was dislocated. They attempted to place shoulder back into place but were unsuccessful. Resident was sent back to the facility with orders for Resident R1 to follow up with ortho (orthopedic- a doctor who treats injuries involving muscles, bones, joints, ligaments, and tendons). Upon investigation it was found that the resident should have been lifted by a mechanical lift for transfers. All of the nursing staff will be re-educated on checking the Task list for transfer requirements prior to moving the resident. Resident R1 had a follow-up appointment with her previous surgeon, and she is scheduled to undergo surgery to replace shoulder.</p> <p>Review of Resident R1's nursing progress note dated 8/2/24, at 10:49 a.m. revealed that Resident R1 left for her surgical procedure appointment for her right arm slightly after 10am. Medicated for pain prior to leaving.</p> <p>Review of documentation provided by the facility dated 8/4/24, indicated that Resident R1's fall that occurred on 7/29/24, had been investigated and the facility determined that due to NA Employee E2 Not adhering to the task list of using the mechanical lift causing the resident to fall, this incident is neglect.</p> <p>Review of a written witness statement dated 8/4/24, from Nurse Aide (NA) Employee E2 stated: I called NA Employee E1 to assist me with Resident R1 as she was standing by the rail. She (Resident R1) stated 'my legs are giving out'. NA Employee E1 and myself lowered her.</p> <p>Review of a written witness statement dated 8/5/24, from NA Employee E3 stated: NA Employee E2 ask me for help and I said Resident R1 was a lift (mechanical lift) and she left and ask help to another NA.</p> <p>Review of Resident R1's Kardex (a snapshot of a resident's care needs) indicated that resident was to be transferred via a full body mechanical lift as per Physical Therapy instruction.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 8/15/24, at 11:14 a.m. Physical Therapist (PT) Employee E4 indicated that Resident R1 required a Hoyer for transfers per the evaluation completed on 7/22/24 and that this information was placed into the Kardex at the time of the evaluation so that it could be communicated to the nurse aides.</p> <p>During an interview on 8/15/24, at 11:20 a.m. Occupational Therapist (OT) Employee E5 stated that if a resident requires a Hoyer for transfers that staff should use the Hoyer to transfer the resident to a shower bed when the resident requires a shower. After the shower, the resident should be dried off while on the shower bed, covered up, and then be transferred back to their room where staff would use the Hoyer to place them back in bed and dress them while they are in bed.</p> <p>During an interview on 8/15/24, at 11:38 a.m. NA Employee E1 confirmed that she was present when Resident R1 was lowered to the ground on 7/29/24, in the shower room. NA Employee E1 stated that she was not familiar with Resident R1 as she had not taken care of her lately, but that NA Employee E2 asked her for help and I was trusting my coworker in regards to how Resident R1 transferred. She added that transfer status if located in the Kardex and is easily located. NA Employee E1 also confirmed that NA Employee E2 had Resident R1 in a shower chair, and not a shower bed, which is typically used for residents requiring a Hoyer.</p> <p>During an interview on 8/15/24, at 11:48 a.m. NA Employee E3 stated that transfer information is located in the Kardex and that is how she knew Resident R1's transfer status and that she required a Hoyer.</p> <p>During an interview on 8/15/24, at 11:58 a.m. Resident R1 confirmed that she had her surgery to repair her shoulder. State Agency informed Resident R1 of awareness of fall in the shower room. Resident R1 replied that she first fell a few days prior when An aide was changing my diaper and rolled me onto my side and pushed me too hard and I went over the side of the bed. I tried to brace myself with my arm and hurt my arm. I kept complaining of pain and they sent me to the ER a couple of days later (7/30/24). The CT scan (computed tomography- a medical imaging technique used to obtain detailed internal images of the body) showed my arm was out of socket and they tried twice to put it back in with no success so I needed surgery on Friday (8/2/24). I'm just pissed that this all had to happen. It's been inconvenient going back and forth (for treatment).</p> <p>Review of Resident R1's medical record did not reveal any documentation regarding Resident R1's account of the fall that occurred when she was rolled out of the bed prior to her fall in the shower room.</p> <p>During an interview on 8/15/24, at 12:52 p.m. Nursing Home Administrator (NHA) stated that Resident R1 did fall out of bed on 7/22/24.</p> <p>During an additional interview on 8/15/24, at 12:55 p.m. NHA confirmed that this fall was not documented in Resident R1's medical record and that the fall was not investigated.</p> <p>During an interview on 8/15/24, at 1:30 p.m. Director of Nursing stated that NA Employee E2 was relieved of her duties on 8/8/24, related to the improper transfer of Resident R1 during the fall that occurred on 7/29/24</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 8/15/24, at 1:40 p.m. NA Employee E6 stated that resident transfer orders are located in the Kardex, and if a resident were ordered a Hoyer for transfer and needed a shower she would Grab another aide and a Hoyer and transfer them onto a shower bed and dress them in their bed.</p> <p>During an interview on 8/15/24, at 3:45 p.m. the Nursing Home Administrator and the Director of Nursing confirmed that the facility failed to provide appropriate goods and services to prevent falls, resulting in neglect for one of two residents (Resident R1), which resulted in actual harm of a dislocated shoulder for Resident R1.</p> <p>28 Pa Code 201.14(a) Responsibility of licensee.</p> <p>28 Pa Code 201.18(b)(1)(e)(1) Management.</p> <p>28 Pa Code 201.29(a)(j) Resident rights.</p> <p>28 Pa Code 211.12(d)(1)(3)(5) Nursing services.</p>		

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement policies and procedures to prevent abuse, neglect, and theft.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46167</p> <p>Based on review of facility documents, facility policy, clinical records, and staff interviews, it was determined that the facility failed to implement written policies and procedures to conduct a thorough investigation of an incident to rule out neglect for one of two residents (Resident R1) involving a fall sustained while receiving care.</p> <p>Findings include:</p> <p>Review of facility policy Abuse and Neglect- Clinical Protocol, review date undetermined, indicated that neglect is defined as the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress.</p> <p>Review of the facility policy Abuse, Neglect, Exploitation or Misappropriation- Reporting and Investigating, review date undetermined, indicated that All reports of resident abuse (including injuries of unknown origin), neglect, exploitation, or theft/misappropriation or resident property are reported to local, state and federal agencies (as required by current regulation) and thoroughly investigated by facility management, Finding of all investigations are documented and reported.</p> <p>Review of the facility job description for Certified Nursing Assistant, indicated that the purpose of the job position is to provide each resident with routine daily nursing care and services in accordance with the resident's assessment and care plan and as may be directed by your supervisor in accordance with the requirements of the policies and procedures of this facility in accordance with current federal, state, and local standards governing the facility. Job duties include assisting with lifting, turning, moving, positioning, and transporting residents into and out of beds, chairs, bathtubs, wheelchairs, lifts, etc.</p> <p>Review of Resident R1's admission record indicated she was admitted to the facility on [DATE].</p> <p>Review of Resident R1's Minimum Data Set (MDS) assessment (mandated assessment of a resident's abilities and care needs) dated 6/17/24, indicated diagnoses Vitamin C deficiency, and generalized edema (fluid accumulation that affects the whole body).</p> <p>Review of Resident R1's admission record indicated additional diagnoses of muscle wasting and atrophy (decrease in size).</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of documentation provided by the facility dated 8/1/24, stated the following: Resident R1 was admitted to the facility on [DATE]. On 7/29/24 the resident was given a shower and as two nurse aides stood her to dress her in the shower room by standing her up at grab bar. Resident R1's legs gave out and she was assisted to the ground resulting in a fall. Description of Follow-up Action: The resident was immediately assessed by the registered nurse, and she was lifted off the floor. Vital signs were at baseline. No bruising or injuries noted. Doctor and POA (power of attorney- a person who is legally named to act on someone else's behalf) notified. Fall protocol initiated. Increased pain was found in the left arm over the next day. CRNP (Certified Registered Nurse Practitioner) notified of increased pain and came to assess the resident. CRNP gave orders for the resident to be sent out to the ER (emergency room) for possible trauma to the left bicep. On 7/31/24 it was founded that Resident R1's left shoulder was dislocated. They attempted to place shoulder back into place but were unsuccessful. Resident was sent back to the facility with orders for Resident R1 to follow up with ortho (orthopedic- a doctor who treats injuries involving muscles, bones, joints, ligaments, and tendons). Upon investigation it was found that the resident should have been lifted by a mechanical lift for transfers. All of the nursing staff will be re-educated on checking the Task list for transfer requirements prior to moving the resident. Resident R1 had a follow-up appointment with her previous surgeon, and she is scheduled to undergo surgery to replace shoulder.</p> <p>During an interview on 8/15/24, at 11:58 a.m. Resident R1 confirmed that she had her surgery to repair her shoulder. State Agency informed Resident R1 of awareness of fall in the shower room. Resident R1 replied that she first fell a few days prior when An aide was changing my diaper and rolled me onto my side and pushed me too hard and I went over the side of the bed. I tried to brace myself with my arm and hurt my arm. I kept complaining of pain and they sent me to the ER a couple of days later (7/30/24). The CT scan (computed tomography- a medical imaging technique used to obtain detailed internal images of the body) showed my arm was out of socket and they tried twice to put it back in with no success so I needed surgery on Friday (8/2/24). I'm just pissed that this all had to happen. It's been inconvenient going back and forth (for treatment).</p> <p>Review of Resident R1's medical record did not reveal any documentation regarding Resident R1's account of the fall that occurred when she was rolled out of the bed prior to her fall in the shower room.</p> <p>During an interview on 8/15/24, at 12:52 p.m. Nursing Home Administrator (NHA) stated that Resident R1 did fall out of bed on 7/22/24.</p> <p>During an additional interview on 8/15/24, at 12:55 p.m. NHA confirmed that this fall was not documented in Resident R1's medical record and that the fall was not investigated.</p> <p>During an interview on 8/15/24, at 3:45 p.m. the Nursing Home Administrator and the Director of Nursing confirmed that the facility failed to implement written policies and procedures to ensure a complete and thorough investigation of an incident involving the potential for neglect for one of two residents (Resident R1) involving a fall sustained while receiving care on 7/22/24.</p> <p>28 Pa. Code 201.14(a) Responsibility of licensee.</p> <p>28 Pa. Code 201.18(e)(1) Management.</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46167</p> <p>Based on review of facility documents, facility policy, clinical records, and staff interviews, it was determined that the facility failed to conduct a thorough investigation of an incident to rule out neglect for one of two residents (Resident R1) involving a fall sustained while receiving care.</p> <p>Findings include:</p> <p>Review of facility policy Abuse and Neglect- Clinical Protocol, review date undetermined, indicated that neglect is defined as the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress.</p> <p>Review of the facility policy Abuse, Neglect, Exploitation or Misappropriation- Reporting and Investigating, review date undetermined, indicated that All reports of resident abuse (including injuries of unknown origin), neglect, exploitation, or theft/misappropriation or resident property are reported to local, state and federal agencies (as required by current regulation) and thoroughly investigated by facility management, Finding of all investigations are documented and reported.</p> <p>Review of the facility job description for Certified Nursing Assistant, indicated that the purpose of the job position is to provide each resident with routine daily nursing care and services in accordance with the resident's assessment and care plan and as may be directed by your supervisor in accordance with the requirements of the policies and procedures of this facility in accordance with current federal, state, and local standards governing the facility. Job duties include assisting with lifting, turning, moving, positioning, and transporting residents into and out of beds, chairs, bathtubs, wheelchairs, lifts, etc.</p> <p>Review of Resident R1's admission record indicated she was admitted to the facility on [DATE].</p> <p>Review of Resident R1's Minimum Data Set (MDS) assessment (mandated assessment of a resident's abilities and care needs) dated 6/17/24, indicated diagnoses Vitamin C deficiency, and generalized edema (fluid accumulation that affects the whole body).</p> <p>Review of Resident R1's admission record indicated additional diagnoses of muscle wasting and atrophy (decrease in size).</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of documentation provided by the facility dated 8/1/24, stated the following: Resident R1 was admitted to the facility on [DATE]. On 7/29/24 the resident was given a shower and as two nurse aides stood her to dress her in the shower room by standing her up at grab bar. Resident R1's legs gave out and she was assisted to the ground resulting in a fall. Description of Follow-up Action: The resident was immediately assessed by the registered nurse, and she was lifted off the floor. Vital signs were at baseline. No bruising or injuries noted. Doctor and POA (power of attorney- a person who is legally named to act on someone else's behalf) notified. Fall protocol initiated. Increased pain was found in the left arm over the next day. CRNP (Certified Registered Nurse Practitioner) notified of increased pain and came to assess the resident. CRNP gave orders for the resident to be sent out to the ER (emergency room) for possible trauma to the left bicep. On 7/31/24 it was founded that Resident R1's left shoulder was dislocated. They attempted to place shoulder back into place but were unsuccessful. Resident was sent back to the facility with orders for Resident R1 to follow up with ortho (orthopedic- a doctor who treats injuries involving muscles, bones, joints, ligaments, and tendons). Upon investigation it was found that the resident should have been lifted by a mechanical lift for transfers. All of the nursing staff will be re-educated on checking the Task list for transfer requirements prior to moving the resident. Resident R1 had a follow-up appointment with her previous surgeon, and she is scheduled to undergo surgery to replace shoulder.</p> <p>During an interview on 8/15/24, at 11:58 a.m. Resident R1 confirmed that she had her surgery to repair her shoulder. State Agency informed Resident R1 of awareness of fall in the shower room. Resident R1 replied that she first fell a few days prior when An aide was changing my diaper and rolled me onto my side and pushed me too hard and I went over the side of the bed. I tried to brace myself with my arm and hurt my arm. I kept complaining of pain and they sent me to the ER a couple of days later (7/30/24). The CT scan (computed tomography- a medical imaging technique used to obtain detailed internal images of the body) showed my arm was out of socket and they tried twice to put it back in with no success so I needed surgery on Friday (8/2/24). I'm just pissed that this all had to happen. It's been inconvenient going back and forth (for treatment).</p> <p>Review of Resident R1's medical record did not reveal any documentation regarding Resident R1's account of the fall that occurred when she was rolled out of the bed prior to her fall in the shower room.</p> <p>During an interview on 8/15/24, at 12:52 p.m. Nursing Home Administrator (NHA) stated that Resident R1 did fall out of bed on 7/22/24.</p> <p>During an additional interview on 8/15/24, at 12:55 p.m. NHA confirmed that this fall was not documented in Resident R1's medical record and that the fall was not investigated.</p> <p>During an interview on 8/15/24, at 3:45 p.m. the Nursing Home Administrator and the Director of Nursing confirmed that the facility failed to conduct a thorough investigation of an incident to rule out neglect for one of two residents (Resident R1) involving a fall sustained while receiving care on 7/22/24.</p> <p>28 Pa Code: 201.18 (e)(1)(2) Management</p> <p>28 Pa Code: 201.29 (a)(c)(d) Resident Rights</p> <p>28 Pa Code: 211.12 (a)(c)(d)(1)(3)(5) Nursing services</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46167</p> <p>Based on a review of Resident Assessment Instrument (RAI) User's Manual, clinical records, and staff interviews, it was determined that the facility failed to ensure that MDS assessments accurately reflected the resident's status for one of two residents (Resident R1).</p> <p>Findings include:</p> <p>The Resident Assessment Instrument (RAI) User's Manual, which gives instructions for completing Minimum Data Set (MDS) assessments (mandated assessments of a resident's abilities and care needs), dated October 2023, indicated the following instructions:</p> <p>-Observation (Look-Back, Assessment) Period is the time period over which the resident's condition or status is captured by the MDS assessment. Most MDS items themselves require an observation period, such as 7 or 14 days, depending on the item. Since a day begins at 12:00 a.m. and ends at 11:59 p.m., the observation period must also cover this time period. A standard 7-day look-back period counts back from and includes the Assessment Reference Date (ARD+6 previous days).</p> <p>-Section C: Resident interview should be conducted because the resident is at least sometimes understood verbally, in writing, or using another method, and if an interpreter is needed, one is available.</p> <p>Review of Resident R1's admission record indicated she was admitted to the facility on [DATE].</p> <p>Review of Resident R1's MDS assessment dated [DATE], indicated diagnoses Vitamin C deficiency, and generalized edema (fluid accumulation that affects the whole body).</p> <p>Review of Resident R1's admission record indicated additional diagnoses of muscle wasting and atrophy (decrease in size).</p> <p>Review of the MDS assessment completed on 10/16/23, Section B: Hearing, Speech, and Vision, question B0700 measures the resident's ability to express ideas and wants indicated that Resident R1 is understood, and question B0800 measures the resident's ability to understand others indicated that Resident R1 understands. Review of Section C: Cognitive Patterns, Question C0100 indicated that Resident R41 is rarely/never understood, and the BIMS (brief interview for mental status) assessment was not completed.</p> <p>State Agency (SA) conducted an interview on 8/15/24, at 11:58 a.m. with Resident R1 regarding a recent fall and surgery. Resident R1 was very clear in her speech, and answered questions appropriately The following is part of the conversation: An aide was changing my diaper and rolled me onto my side and pushed me too hard and I went over the side of the bed. I tried to brace myself with my arm and hurt my arm. I kept complaining of pain and they sent me to the ER a couple of days later (7/30/24). The CT scan (computed tomography- a medical imaging technique used to obtain detailed internal images of the body) showed my arm was out of socket and they tried twice to put it back in with no success so I needed surgery on Friday (8/2/24). I'm just pissed that this all had to happen. It's been inconvenient going back and forth (for treatment).</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395732	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/15/2024
NAME OF PROVIDER OR SUPPLIER Heritage Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 5701 Phillips Avenue Pittsburgh, PA 15217	
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 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of medical records and interviews with staff confirmed that Resident R1's account of events were accurate.</p> <p>During an interview on 8/15/24, at 12:40 p.m. Director of Nursing (DON) was informed of discrepancy between MDS answer that resident is rarely/never understood, and the clarity of the interview that had just occurred between SA and Resident R1. DON stated that typically a Social Worker would conduct that part of the interview that would be utilized to fill out Section C of the MDS, and BIMS score, however there was a gap in coverage with Social Workers and the RNAC (registered nurse assessment coordinator) was completing this section during this time.</p> <p>During an interview on 8/15/24, at 12:42 p.m. RNAC Employee E7 confirmed that she had completed Section C on the above mentioned MDS completed on 6/17/24. When SA explained the discrepancy between MDS answer that resident is rarely/never understood, and the clarity of the interview that had just occurred between State Agency and Resident R1, RNAC Employee E7 stated it depends on how much medication she has had.</p> <p>During an interview on 8/15/24, at 2:01 p.m. Physical Therapy (PT) Employee E4 stated that she is familiar with Resident R1. When asked about her mental status, PT Employee E4 stated that Resident R1's medication can make her mental status fuzzy sometimes, but that Resident R1 can absolutely make her needs known, and is understood.</p> <p>During an interview on 11/22/23, at 11:30 a.m. the Nursing Home Administrator and DON confirmed that Residents R1 is cognitively intact, and should have had BIMS assessments completed, and that the facility failed to ensure that MDS assessments accurately reflected the resident's status for one of two residents.</p> <p>28 Pa. Code: 211.12(d)(1)(2)(3)(5) Nursing Services.</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46167</p> <p>Based on review of clinical records, resident interview, and staff interviews, it was determined that the facility failed to document and/or institute interventions for a fall for one of two residents (Residents R1).</p> <p>Findings include:</p> <p>Review of the facility job description for Certified Nursing Assistant, indicated that the purpose of the job position is to provide each resident with routine daily nursing care and services in accordance with the resident's assessment and care plan and as may be directed by your supervisor in accordance with the requirements of the policies and procedures of this facility in accordance with current federal, state, and local standards governing the facility. Job duties include assisting with lifting, turning, moving, positioning, and transporting residents into and out of beds, chairs, bathtubs, wheelchairs, lifts, etc.</p> <p>Review of Resident R1's admission record indicated she was admitted to the facility on [DATE].</p> <p>Review of Resident R1's Minimum Data Set (MDS) assessment (mandated assessment of a resident's abilities and care needs) dated 6/17/24, indicated diagnoses Vitamin C deficiency, and generalized edema (fluid accumulation that affects the whole body).</p> <p>Review of Resident R1's admission record indicated additional diagnoses of muscle wasting and atrophy (decrease in size).</p> <p>Review of documentation provided by the facility dated 8/1/24, stated the following: Resident R1 was admitted to the facility on [DATE]. On 7/29/24 the resident was given a shower and as two nurse aides stood her to dress her in the shower room by standing her up at grab bar. Resident R1's legs gave out and she was assisted to the ground resulting in a fall. Description of Follow-up Action: The resident was immediately assessed by the registered nurse, and she was lifted off the floor. Vital signs were at baseline. No bruising or injuries noted. Doctor and POA (power of attorney- a person who is legally named to act on someone else's behalf) notified. Fall protocol initiated. Increased pain was found in the left arm over the next day. CRNP (Certified Registered Nurse Practitioner) notified of increased pain and came to assess the resident. CRNP gave orders for the resident to be sent out to the ER (emergency room) for possible trauma to the left bicep. On 7/31/24 it was founded that Resident R1's left shoulder was dislocated. They attempted to place shoulder back into place but were unsuccessful. Resident was sent back to the facility with orders for Resident R1 to follow up with ortho (orthopedic- a doctor who treats injuries involving muscles, bones, joints, ligaments, and tendons). Upon investigation it was found that the resident should have been lifted by a mechanical lift for transfers. All of the nursing staff will be re-educated on checking the Task list for transfer requirements prior to moving the resident. Resident R1 had a follow-up appointment with her previous surgeon, and she is scheduled to undergo surgery to replace shoulder.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 8/15/24, at 11:58 a.m. Resident R1 confirmed that she had her surgery to repair her shoulder. State Agency informed Resident R1 of awareness of fall in the shower room. Resident R1 replied that she first fell a few days prior when An aide was changing my diaper and rolled me onto my side and pushed me too hard and I went over the side of the bed. I tried to brace myself with my arm and hurt my arm. I kept complaining of pain and they sent me to the ER a couple of days later (7/30/24). The CT scan (computed tomography- a medical imaging technique used to obtain detailed internal images of the body) showed my arm was out of socket and they tried twice to put it back in with no success so I needed surgery on Friday (8/2/24). I'm just pissed that this all had to happen. It's been inconvenient going back and forth (for treatment).</p> <p>Review of Resident R1's medical record did not reveal any documentation regarding Resident R1's account of the fall that occurred when she was rolled out of the bed prior to her fall in the shower room.</p> <p>During an interview on 8/15/24, at 12:52 p.m. Nursing Home Administrator (NHA) stated that Resident R1 did fall out of bed on 7/22/24.</p> <p>During an additional interview on 8/15/24, at 12:55 p.m. NHA confirmed that this fall was not documented in Resident R1's medical record and that the fall was not investigated.</p> <p>During an interview on 8/15/24, at 3:45 p.m. the Nursing Home Administrator and the Director of Nursing confirmed that the facility failed to document and/or institute interventions for a fall sustained on 7/22/24, for one of two residents (Resident R1).</p> <p>28 Pa. Code 201.18 (b)(1) Management.</p> <p>28 Pa. Code 201.29(d) Resident rights.</p> <p>28 Pa. Code 211.10 (c)(d) Resident care policies.</p> <p>28 Pa. Code 211.12 (d)(1)(2)(3)(5) Nursing services.</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46167</p> <p>Based on review of facility documents, clinical records, resident interview, and staff interviews, it was determined that the facility failed to provide appropriate assistance with an appropriate device to prevent falls for one of two residents (Resident R1), which resulted in actual harm of a dislocated shoulder for Resident R1.</p> <p>Findings include:</p> <p>Review of the facility job description for Certified Nursing Assistant, indicated that the purpose of the job position is to provide each resident with routine daily nursing care and services in accordance with the resident's assessment and care plan and as may be directed by your supervisor in accordance with the requirements of the policies and procedures of this facility in accordance with current federal, state, and local standards governing the facility. Job duties include assisting with lifting, turning, moving, positioning, and transporting residents into and out of beds, chairs, bathtubs, wheelchairs, lifts, etc.</p> <p>Review of Resident R1's admission record indicated she was admitted to the facility on [DATE].</p> <p>Review of Resident R1's Minimum Data Set (MDS) assessment (mandated assessment of a resident's abilities and care needs) dated 6/17/24, indicated diagnoses Vitamin C deficiency, and generalized edema (fluid accumulation that affects the whole body).</p> <p>Review of Resident R1's admission record indicated additional diagnoses of muscle wasting and atrophy (decrease in size).</p> <p>Review of Resident R1's Physical Therapy evaluation dated 7/22/24, indicated that resident requires maximum assistance of two people with a mechanical lift (Hoyer- a device used to safely lift a person with minimal physical effort) for transfers form one surface to another.</p> <p>Review of Resident R1's medical record revealed a nursing progress note dated 7/30/24, at 10:42 p.m. that stated; Resident left facility via stretcher by 911 (non-emergent) to hospital for trauma to left bicep. Safety maintained.</p> <p>Review of a written witness statement dated 7/31/24, from NA Employee E1 stated: Resident R1 was in the shower room on shower chair. NA Employee E2 asked me if I can assist her with putting resident in wheelchair. We stood resident up in shower at bar. Once she (Resident R1) stood she said her legs was 'giving out'. We tried to reach for wheelchair but it was too far so we lower her to the floor.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of documentation provided by the facility dated 8/1/24, stated the following: Resident R1 was admitted to the facility on [DATE]. On 7/29/24 the resident was given a shower and as two nurse aides stood her to dress her in the shower room by standing her up at grab bar. Resident R1's legs gave out and she was assisted to the ground resulting in a fall. Description of Follow-up Action: The resident was immediately assessed by the registered nurse, and she was lifted off the floor. Vital signs were at baseline. No bruising or injuries noted. Doctor and POA (power of attorney- a person who is legally named to act on someone else's behalf) notified. Fall protocol initiated. Increased pain was found in the left arm over the next day. CRNP (Certified Registered Nurse Practitioner) notified of increased pain and came to assess the resident. CRNP gave orders for the resident to be sent out to the ER (emergency room) for possible trauma to the left bicep. On 7/31/24 it was founded that Resident R1's left shoulder was dislocated. They attempted to place shoulder back into place but were unsuccessful. Resident was sent back to the facility with orders for Resident R1 to follow up with ortho (orthopedic- a doctor who treats injuries involving muscles, bones, joints, ligaments, and tendons). Upon investigation it was found that the resident should have been lifted by a mechanical lift for transfers. All of the nursing staff will be re-educated on checking the Task list for transfer requirements prior to moving the resident. Resident R1 had a follow-up appointment with her previous surgeon, and she is scheduled to undergo surgery to replace shoulder.</p> <p>Review of Resident R1's nursing progress note dated 8/2/24, at 10:49 a.m. stated that Resident R1 left for her surgical procedure appointment for her right arm slightly after 10am. Medicated for pain prior to prior to leaving.</p> <p>Review of a written witness statement dated 8/4/24, from Nurse Aide (NA) Employee E2 stated: I called NA Employee E1 to assist me with Resident R1 as she was standing by the rail. She (Resident R1) stated 'my legs are giving out'. NA Employee E1 and myself lowered her.</p> <p>Review of a written witness statement dated 8/5/24, from NA Employee E3 stated: NA Employee E2 ask me for help and I said Resident R1 was a lift (mechanical lift) and she left and ask help to another NA.</p> <p>Review of Resident R1's Kardex (a snapshot of a resident's care needs) indicated that resident was to be transferred via a full body mechanical lift as per Physical Therapy instruction.</p> <p>During an interview on 8/15/24, at 11:14 a.m. Physical Therapist (PT) Employee E4 indicated that Resident R1 required a Hoyer for transfers per the evaluation completed on 7/22/24 and that this information was placed into the Kardex at the time of the evaluation so that it could be communicated to the nurse aides.</p> <p>During an interview on 8/15/24, at 11:20 a.m. Occupational Therapist (OT) Employee E5 stated that if a resident requires a Hoyer for transfers that staff should use the Hoyer to transfer the resident to a shower bed when the resident requires a shower. After the shower, the resident should be dried off while on the shower bed, covered up, and then be transferred back to their room where staff would use the Hoyer to place them back in bed and dress them while they are in bed.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 8/15/24, at 11:38 a.m. NA Employee E1 confirmed that she was present when Resident R1 was lowered to the ground on 7/29/24, in the shower room. NA Employee E1 stated that she was not familiar with Resident R1 as she had not taken care of her lately, but that NA Employee E2 asked her for help and I was trusting my coworker in regards to how Resident R1 transferred. She added that transfer status if located in the Kardex and is easily located. NA Employee E1 also confirmed that NA Employee E2 had Resident R1 in a shower chair, and not a shower bed, which is typically used for residents requiring a Hoyer.</p> <p>During an interview on 8/15/24, at 11:48 a.m. NA Employee E3 stated that transfer information is located in the Kardex and that is how she knew Resident R1's transfer status and that she required a Hoyer.</p> <p>During an interview on 8/15/24, at 11:58 a.m. Resident R1 confirmed that she had her surgery to repair her shoulder. State Agency informed Resident R1 of awareness of fall in the shower room. Resident R1 replied that she first fell a few days prior when An aide was changing my diaper and rolled me onto my side and pushed me too hard and I went over the side of the bed. I tried to brace myself with my arm and hurt my arm. I kept complaining of pain and they sent me to the ER a couple of days later (7/30/24). The CT scan (computed tomography- a medical imaging technique used to obtain detailed internal images of the body) showed my arm was out of socket and they tried twice to put it back in with no success so I needed surgery on Friday (8/2/24). I'm just pissed that this all had to happen. It's been inconvenient going back and forth (for treatment).</p> <p>Review of Resident R1's medical record did not reveal any documentation regarding Resident R1's account of the fall that occurred when she was rolled out of the bed prior to her fall in the shower room.</p> <p>During an interview on 8/15/24, at 12:52 p.m. Nursing Home Administrator (NHA) stated that Resident R1 did fall out of bed on 7/22/24.</p> <p>During an additional interview on 8/15/24, at 12:55 p.m. NHA confirmed that this fall was not documented in Resident R1's medical record and that the fall was not investigated.</p> <p>During an interview on 8/15/24, at 1:30 p.m. Director of Nursing stated that NA Employee E2 was relieved of her duties on 8/8/24, related to the improper transfer of Resident R1 during the fall that occurred on 7/29/24.</p> <p>During an interview on 8/15/24, at 1:40 p.m. NA Employee E6 stated that resident transfer orders are located in the Kardex, and if a resident were ordered a Hoyer for transfer and needed a shower she would Grab another aide and a Hoyer and transfer them onto a shower bed and dress them in their bed.</p> <p>During an interview on 8/15/24, at 3:45 p.m. the Nursing Home Administrator and the Director of Nursing confirmed that the facility failed to provide appropriate assistance with an appropriate device to prevent falls for one of two residents (Resident R1), which resulted in actual harm of a dislocated shoulder for Resident R1.</p> <p>28 Pa. Code 201.14(a) Responsibility of licensee.</p> <p>(continued on next page)</p>		

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F 0689 Level of Harm - Actual harm Residents Affected - Few	28 Pa. Code 201.18(b)(1)(e)(1) Management. 28 Pa. Code 201.20(b)(1) Staff Development. 28 Pa. Code 201.29(a) Resident rights. 28 Pa. Code 211.10(c)(d) Resident care policies. 28 Pa. Code 211.11(d) Resident care plan.

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46167</p> <p>Based on review of facility policy, clinical records, and staff interviews it was determined that the facility failed to ensure that the physician order indicated a catheter size for a urinary catheter (insertion of a tube into the bladder to remove urine) for one of two residents (Residents R2).</p> <p>Findings include:</p> <p>Review of facility policy Indwelling Catheter Insertion, review date undetermined, indicated that a physician's order should be present, and that the size of the catheter and the amount of sterile water used to inflate the balloon should be documented.</p> <p>Review of admission record indicated that Resident R2 was admitted on [DATE].</p> <p>Review of Resident R2's Minimum Data Set Assessment (MDS, periodic assessment of resident care needs) dated 6/30/24, indicated diagnoses of obstructive uropathy (restriction in the flow of urine), difficulty swallowing, and pain. Section H - Bladder and Bowel indicated the utilization of an indwelling catheter.</p> <p>Review of Resident R2 's physician order dated 6/27/24, indicated to perform catheter care every shift, and to empty catheter every shift, but did not have a physician's order regarding the size of the foley catheter and balloon.</p> <p>During an interview on 9/15/24, at 9:50 a.m., the Director of Nursing confirmed the facility failed to ensure that the physician order indicated a catheter size for the use urinary catheter and balloon as required for one of two resident (Resident R2).</p> <p>28 Pa Code: 201.14 (a) Responsibility of licensee.</p> <p>28 Pa code: 211.10 (c)(d) Resident care policies.</p> <p>28 Pa. Code 211.12(d)(1)(3)(5) Nursing services.</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>46167</p> <p>Based on review of facility policies, observations and staff interview it was determined that the facility failed to store all drugs and biologicals in a safe, secure, and orderly manner for one of two nursing units (Second floor).</p> <p>Findings include:</p> <p>Review of the facility policy Storage of Medications review date undetermined, indicated that only persons authorized to prepare and administer medications have access to locked medications. Compartments (including, but not limited to drawers, cabinets, rooms, refrigerators, carts, and boxes) containing drugs and biologicals are locked when not in use. Unlocked medication carts are not left unattended.</p> <p>During an observation and interview on 8/15/24, at 11:44 a.m. the door to the Second Floor medication room was propped open, and contained a treatment cart containing medications that was unlocked. Assistance Director of Nursing Employee E8 Employee confirmed that the facility failed to store all drugs and biologicals in a safe, and secure manner for one of two nursing units (Second Floor).</p> <p>28 Pa Code: 211.9 (a) Pharmacy services.</p> <p>28 Pa code: 211.12 (d) (1) (5) Nursing services.</p>		