STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395778	A. Building B. Wing	10/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Communities at Indian Haven,	1675 Saltsburg Avenue Indiana, PA 15701

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 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31760 Based on review of the Resident Assessment Instrument User's Manual and residents' clinical records, as well as staff interviews, it was determined that the facility failed to ensure that comprehensive admission Minimum Data Set assessments were completed in the required timeframe for two of 11 residents reviewed (Residents 2, 4). Findings include: The Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual, which provides instructions and guidelines for completing required Minimum Data Set (MDS) assessments (mandated assessments of a resident's abilities and care needs), dated October 2024, indicated that for admission MDS assessments, the assessment completion date was to be no later than the resident's admitted plus 13 calendar days. An admission Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 2, dated August 22, 2024, revealed that the resident was admitted on [DATE]. The resident's MDS was documented in section Z0500B as being completed on September 13, 2024, which was 29 days after admission. Interview with the Nursing Home Administrator on October 2, 2024, at 3:35 p.m. confirmed that Resident 2's admission MDS assessment was not completed within the required timeframe. A nursing note for Resident 4, dated August 6, 2024, revealed that the resident was admitted to the facility from home with diagnosis of malignant neoplasm (a cancerous tumor that develops when cells grow and divide abnormally, and can invade nearby tissues and spread to other parts of the body). However, as of October 2, 2024, there was no documented evidence that Resident 4's admission MDS assessment was completed within the required timeframe. Interview with the Nursing Home Administrator on October 2, 2024, at 3:25 p.m. confirmed that there was no documented evidence that Resident 4's admission MDS assessment was completed within the required timeframe. 28 Pa. Code 211.5(f) Clinical Records.

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

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident’s assessment data and transmit these data to the State within 7 days of assessment. 48941 Based on review of the Resident Assessment Instrument User's Manual and residents' clinical records, as well as staff interviews, it was determined that the facility failed to ensure that a quarterly Minimum Data Set assessment was completed in the required timeframe for one of 11 residents reviewed (Resident 1). Findings include: The Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual, which provides instructions and guidelines for completing required Minimum Data Set (MDS) assessments (mandated assessments of a resident's abilities and care needs), dated October 2024, indicated that a quarterly assessment was to have a completion date (Section Z0500B) that was no later than the assessment reference date (ARD-last day of the observation/look-back period) plus 14 calendar days. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 1, with an ARD of August 2, 2024, revealed that the resident's MDS was documented in section Z0500B as being completed on September 3, 2024, which was 32 days after the assessment reference date. Interview with the Nursing Home Administrator on October 2, 2024, at 3:35 p.m. confirmed that Resident 1's quarterly MDS assessment was not completed within the required timeframe. 28 Pa. Code 211.5(f) Clinical Records.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 31760 Based on review of policies and clinical records, as well as staff interviews, it was determined that the facility failed to develop care plans to address individualized resident care needs for one of 11 residents reviewed (Resident 4). Findings include: The facility's policy regarding care plans, dated January 15, 2024, indicated that a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychological and functional needs is developed and implemented for each resident. Assessments of residents are ongoing and care plans are revised as information about the resident and the resident's condition changes. Physician's orders for Resident 4, dated August 16, 2024, included an order for the resident to be admitted to hospice (specialized care that provides physical comfort and emotional, social, and spiritual support for people nearing the end of life). A nursing note for Resident 4, dated August 7, 2024, revealed that the resident was seen by the physician regarding his admission to the facility and that the resident was on hospice. A nursing note for Resident 4, dated August 16, 2024, revealed that the resident's power of attorney stopped the services from the resident's initial hospice provider and changed to another hospice provider effective that date. However, as of October 2, 2024, there was no documented evidence that a care plan was developed to address Resident 4's individualized care needs related to him being on hospice. Interview with the Nursing Home Administrator on October 2, 2024, at 3:25 p.m. confirmed that Resident 4 did not have a care plan in place to address the care and treatment required for him being on hospice. 28 Pa. Code 211.10(d) Resident Care Plans.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 31760 Based on review of policies and clinical records, as well as staff interviews, it was determined that the facility failed to ensure that care plans were updated to reflect changes in residents' care needs for three of 11 residents reviewed (Residents 1, 2, 4). Findings include: The facility's policy regarding care plans, dated January 15, 2024, indicated that a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychological and functional needs is developed and implemented for each resident. Assessments of residents are ongoing and care plans are revised as information about the resident and the residents' condition changes. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 1, dated August 2, 2024, revealed that the resident was understood and was able to understand others, required assistance with care needs, received diuretic medications (medications used to treat fluid build-up), and had diagnoses that included congestive heart failure (the heart cannot pump blood as well as it should causing weight gain due to fluid to build up in the lungs and lower legs), hypertension (high blood pressure), and chronic obstructive pulmonary disease (COPD) (chronic lung disease making breathing difficult). A nurse's note for Resident 1, dated September 25, 2024, at 4:34 p.m., revealed that the resident's daughter had concerns related to his recent low blood pressures, diuretic medications, and syncopal (fainting) episodes. A nurse's note for Resident 1, dated September 25, 2024, at 5:07 p.m., revealed that new orders were obtained for blood pressure parameters for his lasix and spironolactone. Physician's orders for Resident 1, dated September 25, 2024, indicated that the resident was to receive 40 milligrams (mg) of Lasix (a diuretic medication) twice daily. Instructions revealed that the Lasix was to be held if his systolic blood pressure (the top number) was less than 110 millimeters of mercury (mm/Hg) or his diastolic blood pressure (the bottom number) was less than 60 millimeters of mercury (mm/Hg). Physician's orders for Resident 1, dated September 26, 2024, indicated that the resident was to receive 25 mg of Spironolactone (a diuretic medication) daily. Instructions revealed that the Spironolactone was to be held if his systolic blood pressure was less than 110 mm/Hg or his diastolic blood pressure was less than 60 mm/Hg. A care plan for Resident 1, dated January 10, 2023, revealed that the resident was taking diuretic medications related to congestive heart failure. There was no documented evidence that the resident's care plan was revised to reflect the blood pressure parameters put in place related to his diuretic medications. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the Nursing Home Administrator on October 2, 2024, at 3:35 p.m. confirmed that Resident 1's care plan was not revised to reflect the blood pressure parameters put in place related to his diuretic medications. An admission Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 2, dated August 22, 2024, revealed that the resident was cognitively intact, was clearly understood and able to clearly understand others, required assistance with care needs, was occasionally incontinent of urine and frequently incontinent of bowel, and had diagnoses that included hemiparesis/hemiplegia (weakness or paralysis to one side of the body due to brain injury). Review of clinical records for Resident 2 revealed that the resident had a preference to receive showers. A shower schedule for her unit indicated that she was to receive a shower weekly on Thursdays in the a.m. A note attached to the shower schedule indicated that the resident's family wanted her to receive a shower more than weekly. There was no documented evidence that Resident 2's care plan was revised to reflect her preference for showers and her family's request for her to receive showers more than weekly. Interview with the Nursing Home Administrator on October 2, 2024, at 3:25 p.m. confirmed that Resident 2's care plan was not updated to reflect her preference for showers and her family's request for her to receive showers more than weekly. A care plan for Resident 4, dated August 20, 2024, revealed that the resident was at high risk for falls related to his terminal illness, weakness, and poor safety awareness. A nursing note for Resident 4, dated September 17, 2024, revealed that the writer was called to assess the resident at this time. The resident was observed lying on the floor on his back to the left side of his bed. The resident remained alert and responsive per his baseline. The resident was transferred back to bed by a mechanical lift. Will add a fall mat to the left side of the resident's bed as a new intervention. Observations of Resident 4 on October 2, 2024, at 11:33 a.m. and 1:45 p.m. revealed that the resident was in his room in a BRODA chair (a specialized wheelchair that provides safe, comfortable, long-term seating that can dramatically reduce the number of falls) in a reclined position. His eyes were closed, and his call bell was on his lap. A fall mat was leaning up against the wall. However, as of October 2, 2024, there was no documented evidence that Resident 4's care plan was updated to reflect the use of the fall mat after the resident's fall from bed on September 17, 2024. Interview with the Nursing Home Administrator on October 2, 2024, at 3:25 p.m. confirmed that Resident 4's care plan was not updated to reflect the use of the fall mat after the resident's fall from bed on September 17, 2024, 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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 48941 Based on review of clinical records, as well as resident and staff interviews, it was determined that the facility failed to maintain clinical records that were complete and accurately documented for one of 11 residents reviewed (Resident 1). Findings include: A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 1, dated August 2, 2024, revealed that the resident was understood and was able to understand others, required assistance with care needs, received diuretic medications (medications used to treat fluid build-up), and had diagnoses that included congestive heart failure (the heart cannot pump blood as well as it should causing weight gain due to fluid to build up in the lungs and lower legs), hypertension (high blood pressure), and chronic obstructive pulmonary disease (COPD) (chronic lung disease making breathing difficult). A nurse's note for Resident 1, dated September 25, 2024, at 4:34 p.m., revealed that the resident's daughter had concerns related to his recent low blood pressures, diuretic medications, and syncopal (fainting) episodes. Physician's orders for Resident 1, dated September 25, 2024, indicated that the resident's orthostatic (lying, sitting, standing) blood pressure (a measurement of blood pressure while a person is lying down, sitting, and standing) was to be monitored daily in the morning for a period of seven days until October 1, 2024. Review of Resident 1's clinical records revealed that the nursing staff were documenting that the orthostatic blood pressures were being obtained, but there was no documented evidence in the resident's clinical record of the obtained results of the orthostatic blood pressures as ordered in the lying, sitting, and standing positions on September 26, 28, and 29, 2024. Interview with the Nursing Home Administrator on October 2, 2024, at 3:50 p.m. confirmed that there was no documented evidence in Resident 1's clinical record of the obtained results of the orthostatic blood pressures as ordered in the lying, sitting, and standing positions on the above-mentioned dates. Physician's orders for Resident 1, dated September 25, 2024, indicated that the resident was to receive 40 milligrams (mg) of Lasix (a diuretic medication) twice daily. Instructions revealed that the Lasix was to be held if his systolic blood pressure (the top number) was less than 110 millimeters of mercury (mm/Hg) or his diastolic blood pressure (the bottom number) was less than 60 millimeters of mercury (mm/Hg). Physician's orders for Resident 1, dated September 26, 2024, indicated that the resident was to receive 25 mg of Spironolactone (a diuretic medication) daily. Instructions revealed that the Spironolactone was to be held if his systolic blood pressure was less than 110 millimeters of mercury (mm/Hg) or his diastolic blood pressure was less than 60. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 1's Medication Administration Record (MAR) for October 2024 revealed that the resident's blood pressure on October 1, 2024, was documented as 88/54 mm/Hg and a dose of 25 mg of Spironolactone was documented as administered. Interview with the Nursing Home Administrator on October 2, 2024, at 2:52 p.m. indicated that she had spoken with the nurse that worked on October 1, 2024, and the nurse indicated that she documented on the report sheet that she had held the Spironolactone at the same time she held the Lasix but documented it incorrectly on the MAR. Review of the MAR for October 2024 indicated that the 40 mg of Lasix was held on October 1, 2024. At this time, the Nursing Home Administrator confirmed that the Spironolactone should have been documented as held on the MAR and it was not. 28 Pa. Code 211.5(f) Clinical Records. 28 Pa. Code 211.12(d)(5) Nursing Services.