

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395778	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/05/2025
NAME OF PROVIDER OR SUPPLIER Communities at Indian Haven,		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</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>38012</p> <p>Based on review of facility policies, clinical records, and investigation documents, as well as staff interviews, it was determined that the facility failed to ensure that residents were free from neglect for one of seven residents reviewed (Resident 3), resulting in Immediate Jeopardy to the resident's physical, mental health, and safety.</p> <p>Findings include:</p> <p>The facility's abuse policy, dated March 4, 2024, revealed that the facility would provide a safe environment where residents are not subject to mental, physical, sexual, and verbal abuse or neglect by staff, residents, volunteers, consultants, contractors, and other caregivers, visitors or family members.</p> <p>A quarterly Minimum Data Set (MDS) assessment (a mandatory assessment of a resident's abilities and care needs) for Resident 3, dated February 19, 2025, revealed that the resident was understood, could understand, was cognitively intact, and had diagnoses that included venous insufficiency (poor circulation) and muscle weakness. Resident 3's care plan, dated May 28, 2024, revealed that the resident required staff assistance for daily care needs, including toileting, hygiene, and dressing, and that the resident was encouraged to ring his call bell for assistance.</p> <p>A statement completed by Housekeeper 1, dated February 21, 2025, revealed that on February 15, 2025, she observed Nurse Aide 2 remove Resident 3's call bell and place it behind him out of his reach. She indicated that she entered the room and gave Resident 3 his call bell back and Nurse Aide 2 told her not to do that. After Nurse Aide 2 left the room, Housekeeper 1 was still cleaning the resident's room when he rang his call bell. Nurse Aide 2 returned to the resident's room and said, See, that's why I took his bell off of him.</p> <p>A statement by Nurse Aide 2, dated February 24, 2025, indicated that she recalled asking Housekeeper 1 why she gave Resident 3 his call bell back. She indicated that she planned to return to his room. She indicated that she did not understand why Housekeeper 1 had to give Resident 3 his call back when she planned to return to the resident's room at some point.</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 - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>A statement completed by the Director of Nursing on February 21, 2025, revealed that he was notified on February 21, 2025, that on Saturday, February 15, 2025, Housekeeper 1 witnessed Nurse Aide 2 remove Resident 3's call bell from his reach and that she told Housekeeper 1 not to give it back to the resident.</p> <p>Interview with Resident 3 on March 5, 2025, at 10:44 a.m. revealed that he recalled a staff member that would take his call bell from him from time to time. She would also tell him not to ring his bell so much because she was busy. He stated that he understood that she was busy because there was a lot of people to take care of at supper time, but that he liked to have his call bell where he could reach it. He stated that he could feed himself, but he had to rely on the staff to do everything else for him. He said he could not recall the nurse aide's name, but that it was always the same one that would take the call bell from him. He could not recall the last time he saw her or the last time that she took his call bell from him.</p> <p>Following the incident on February 15, 2025, Nurse Aide 2 continued to work with Resident 3, as well as other residents on February 16, 18, 19, and 20, 2025. Housekeeper 1 failed to report her observations and concerns for neglect until February 21, 2025. Nurse Aide 2 was suspended from her duties on February 21, 2025, and after the investigation her employment with the facility was terminated. An in-house audit was performed on residents and assessments were completed along with interviews to confirm no other residents were identified. Housekeeper 1 was re-educated regarding abuse, and then quit her position.</p> <p>On March 5, 2025, at 12:41 p.m. the Nursing Home Administrator was given the required Immediate Jeopardy Template and informed that the physical/mental health and safety of the residents was placed in Immediate Jeopardy due to the facility's failure to ensure that Resident 3 was not neglected by Nurse Aide 2 by taking his call bell and placing it out of reach from him.</p> <p>On March 5, 2025, at 3:49 p.m. the facility submitted an immediate action plan that included:</p> <p>The nurse aide was suspended at the time of the reported abuse and is no longer employed at the facility.</p> <p>An in-house audit was performed on residents at the time of the incident, and assessments were completed along with interviews to confirm no other residents were identified.</p> <p>In-house re-education was provided to staff on abuse and reporting of abuse. The facility will not allow an employee to work unless this education has been completed prior to returning to work.</p> <p>Re-education regarding abuse to staff was 99 percent completed by 4:00 p.m. on March 5, 2025.</p> <p>Audits will be conducted weekly for four weeks and monthly for two months to verify compliance and understanding of reporting abuse.</p> <p>Facility staff were interviewed on March 5, 2025, and were knowledgeable of the facility's policy on abuse.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>The Immediate Jeopardy was lifted on March 5, 2025, at 4:08 p.m. when it was confirmed that the corrective action plans developed on March 5, 2025, were completed and that Resident 3 and any other current residents were not neglected.</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(j) Resident Rights.</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>28177</p> <p>Based on review of facility policies, clinical records, and investigation documents, as well as staff interviews, it was determined that the facility failed to ensure that staff reported an allegation of neglect in a timely manner for one of seven residents reviewed (Resident 3).</p> <p>Findings include:</p> <p>The facility's abuse policy, dated March 4, 2024, revealed that all allegations of abuse shall be reported immediately to the charge nurse, Director of Nursing, Nursing Home Administrator, and resident's physician for investigation into the circumstances of the incident. The staff member who discovers the incident, suspected abuse situation, or has the initial knowledge of such incidents will be responsible for immediately notifying his or her supervisor. The supervisor who becomes aware of such incidents must immediately report to the Nursing Home Administrator and Director of Nursing, in person or by telephone.</p> <p>A quarterly Minimum Data Set (MDS) assessment (a mandatory assessment of a resident's abilities and care needs) for Resident 3, dated February 19, 2025, revealed that the resident was understood, could understand, was cognitively intact, and had diagnoses that included venous insufficiency (poor circulation) and muscle weakness. Resident 3's care plan, dated May 28, 2024, revealed that the resident required staff assistance for daily care needs, including toileting, hygiene, and dressing, and that the resident was encouraged to ring his call bell for assistance.</p> <p>A statement completed by Housekeeper 1, dated February 21, 2025, revealed that on February 15, 2025, she observed Nurse Aide 2 remove Resident 3's call bell and place it behind him out of his reach. She indicated that she entered the room and gave Resident 3 his call bell back, and Nurse Aide 2 told her not to do that. After Nurse Aide 2 left the room, Housekeeper 1 was still cleaning the resident's room when he rang his call bell. Nurse Aide 2 returned to the resident's room and said, See, that's why I took his bell off of him.</p> <p>A statement by Nurse Aide 2, dated February 24, 2025, indicated that she recalled asking Housekeeper 1 why she gave Resident 3 his call bell back. She indicated that she planned to return to his room. She indicated that she did not understand why Housekeeper 1 had to give Resident 3 his call back when she planned to return to the resident's room at some point.</p> <p>A statement completed by the Director of Nursing on February 21, 2025, revealed that he was notified on February 21, 2025, that on Saturday, February 15, 2025, Housekeeper 1 witnessed Nurse Aide 2 remove Resident 3's call bell from his reach and that she told Housekeeper 1 not to give it back to the resident.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview with Resident 3 on March 5, 2025, at 10:44 a.m. revealed that he recalled a staff member that would take his call bell from him from time to time. She would also tell him not to ring his bell so much because she was busy. He stated that he understood that she was busy because there was a lot of people to take care of at supper time, but that he liked to have his call bell where he could reach it. He stated that he could feed himself, but he had to rely on the staff to do everything else for him. He said he could not recall the nurse aide's name, but that it was always the same one that would take the call bell from him. He could not recall the last time he saw her or the last time that she took his call bell from him.</p> <p>Following the incident on February 15, 2025, Nurse Aide 2 continued to work with Resident 3, as well as other residents on February 16, 18, 19, and 20, 2025. Housekeeper 1 failed to report her observations and concerns of neglect until February 21, 2025. Nurse Aide 2 was suspended from her duties on February 21, 2025, and after the investigation her employment with the facility was terminated. An in-house audit was performed on residents and assessments were completed along with interviews to confirm no other residents were identified. Housekeeper 1 was re-educated regarding abuse, and then quit her position.</p> <p>Interview with the Nursing Home Administrator on March 5, 2025, at 11:16 a.m. revealed that Housekeeper 1 was newly hired on February 11, 2025, and was educated regarding reporting abuse. She stated that Housekeeper 1 did not report her concerns until February 21, 2025, and that she should have reported them immediately.</p> <p>28 Pa. Code 201.18(e)(1) Management.</p> <p>28 Pa. Code 211.12(d)(5) Nursing Services.</p>		

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<p>F 0835</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Administer the facility in a manner that enables it to use its resources effectively and efficiently.</p> <p>38012</p> <p>Based on review of job descriptions and the deficiencies cited during the current survey, it was determined that the Nursing Home Administrator (NHA) and the Director of Nursing (DON) failed to assume responsibility for effective management of the facility to ensure that the residents' environment remained free from neglect, and for ensuring that staff reported abuse and protected the residents from further abuse/neglect.</p> <p>Findings include:</p> <p>The job description for the NHA, dated January 15, 2025, indicated that the primary function of this position was to provide general oversight and direction to all services provided by The Communities at Indian Haven. Maintains compliance with the Department of Health, Welfare, Medicare, and Educational regulatory requirements. Supervision and coordination of services to include overseeing budget and corporate policies and procedures related to the care of all residents.</p> <p>The job description for the DON, dated November 26, 2024, indicated that the primary function of this position was to organize, administrate, and supervise the total nursing service program in compliance with the regulatory process and operational guidelines, and modifies nursing care policies and/or procedures to maintain the highest practicable well-being of each resident.</p> <p>The deficiencies cited under the Code of Federal Regulatory Groups for Long-Term Care, 483.12 Freedom from Abuse, Neglect, and Exploitation (F600), revealed that the NHA and DON failed to fulfill their essential job duties for ensuring that the residents' environment remained free from abuse/neglect.</p> <p>The deficiencies cited under the Code of Federal Regulatory Groups for Long-Term Care, 483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property and 483.12(b)(5)(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act, revealed that the NHA and DON failed to fulfill their essential job duties for ensuring that staff reported abuse timely and for allowing staff to return to the resident.</p> <p>Refer to F600.</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 211.12(d)(1)(5) Nursing Services.</p>		