

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395790	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/22/2024
NAME OF PROVIDER OR SUPPLIER Seneca Place		STREET ADDRESS, CITY, STATE, ZIP CODE 5360 Saltsburg Road Verona, PA 15147	

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 - Minimal harm or potential for 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** 46336</p> <p>Based on review of facility policies, job descriptions, documents, clinical records, and staff interviews, it was determined that the facility failed to protect residents from physical neglect for one of three residents reviewed (Resident R1).</p> <p>Findings include:</p> <p>Review of the facility policy Abuse, Neglect, Exploitation and Misappropriation Prevention Program dated, 5/12/24, indicated residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. The objective is to protect residents from abuse, neglect, exploitation, or misappropriation of property by anyone to include facility staff.</p> <p>Review of the facility Nurse Aide Job Description dated May 2024, indicated the Nurse Aide (NA) will provide routine Activities of Daily Living (ADL - personal care activities like bathing, dressing, eating, mobility, and toileting) care in a manner conducive to the comfort and safety of residents and will be responsible for performing person centered care.</p> <p>Review of admission record indicated Resident R1 was admitted to the facility on [DATE].</p> <p>Review of Resident R1's Minimum Data Set (MDS - a periodic assessment of care needs) dated 5/15/24, indicated the diagnoses of stroke (damage to the brain from an interruption of blood supply), Multiple Sclerosis (immune system eats away at protective covering of nerve cells), and unspecified intellectual abilities (a diagnosis given to intellectually disabled individuals who are unable to complete the standardized testing). Section C indicated the Brief Interview for Mental Status (BIMS - a screening test that aides in detecting cognitive impairment) total score of 15 - cognitively intact. Section GG indicated resident requires moderate assistance with toileting and transfers.</p> <p>Review of Resident R1's care plan dated 5/20/24, indicated resident is incontinent of bowel and care plan dated 8/2/24, indicated the resident will have his daily activities of daily living care needs met through the next review date. Anticipate and meet the resident's needs.</p> <p>Review of Resident R1's progress notes indicated the following entries:</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 - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-On 7/19/24, at 12:33 p.m. resident went on leave of absence to MRI (magnetic resonance image - diagnostic test that can detail images of structures and organs inside the body) appointment via wheelchair with stretcher.</p> <p>-On 7/19/24, at 4:09 p.m. resident returned from leave of absence.</p> <p>-On 7/19/24, at 5:34 p.m. resident soiled with bowel movement upon return from MRI appointment. Stated he had asked to be changed prior to going to MRI. NA Employee E2 provided incontinence care and noted dry bowel movement from midback to knees. Skin red but unbroken.</p> <p>Review of facility provided documentation dated 7/19/24, at 3:15 p.m. indicated Resident R1 was scheduled an appointment for an MRI of his brain and spine related to his diagnoses. Resident was scheduled to arrive to the appointment with and escort, the alleged perpetrator Nurse Aide (NA) Employee E1. Prior to leaving the facility at approximately 12:00 p.m., Resident R1 stated to NA Employee E1, that he needed to be changed. NA Employee E1 responded I'll get to it and escorted resident to the appointment without changing him.</p> <p>Further review of facility provided documentation dated 7/19/24, at 3:15 p.m. indicated Resident R1 returned from the medical appointment at approximately 3:15 p.m. NA Employee E1 told NA Employee E2 he didn't feel well and when NA Employee E2 took over the resident's care he was found to be covered in bowel movement.</p> <p>Review of NA Employee E2's witness statement dated 7/19/24, indicated While doing rounds, Resident R1 asked if I would change him because he had a bowel movement a while ago. Once transferred into bed, I noticed it was from his back to almost his knees and was dried.</p> <p>Review of Nursing Home Administrator (NHA) witness statement dated 7/19/24, indicated Registered Nurse (RN) Employee E3 and I were alerted by floor staff of incident involving Resident R1 in which an aide found him heavily soiled from his back to his knees.</p> <p>Review of Resident R1' interview with the Nursing Home Administrator, dated 7/19/24, indicated:</p> <p>-Resident R1 told NA Employee E1 he needed changed prior to leaving for his medical appointment.</p> <p>-NA Employee E1 told Resident R1 I'll get to it. Proceeded to take Resident R1 to appointment without changing him.</p> <p>-Resident R1 was at the appointment from approximately 1:20 p.m. - 3:15 p.m.</p> <p>-Upon return NA Employee E1 did not change Resident R1, told staff he didn't feel well and left the facility.</p> <p>-Resident was changed and skin evaluation indicated red skin without skin breakdown.</p> <p>Interview on 8/20/24, at 10:50 a.m. NA Employee E4 indicated Resident R1 is alert and oriented, he could definitely tell me if he needed to be changed or used the bathroom. If he told me he needed changed, I'd change him right away. He only needs one person to help him in the bathroom.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 8/20/24, at 10:54 a.m. NA Employee E5 indicated If a resident is escorted to an appointment, it's so the NA with them can assist them with toileting while they are out of the facility. Resident R1 needs one helper to toilet, I'd change him right away if he asked me. It's easy.</p> <p>Telephonic interview on 8/20/24, at 11:05 a.m. Facility Van Driver Employee E6 indicated he transported Resident R1 and escort to the local hospital. He indicated the resident didn't tell him he needed changed but did recall an odor. He also picked them up and noticed the same odor.</p> <p>Telephonic interview on 8/20/24, at 11:08 a.m. NA Employee E2 indicated My memory is very good. He was brought in from the appointment and he was sitting in the hallway. Resident R1 calls me a certain name that he likes for me, and asked Do you think you could take me to the bathroom? I moved my bowels and I've been sitting in it for a while. He had a very red backside. The feces was dried like, and from his back to the back of his knees. He told me he asked the young man to take him to the bathroom and he didn't take him, and he sat in it.</p> <p>Interview with the Director of Nursing on 8/20/24, at 11:15 a.m. indicated the facility tried to reach NA Employee E1 for a statement and were unsuccessful. The Nursing Home Administrator came in the facility the following morning to get a statement from him and suspend him, but he never showed up and never called in. NA Employee E1 never returned to the facility.</p> <p>Review of Employee File on 8/20/24, at 11:30 a.m. indicated a hire date 5/20/24, and a termination date of 7/22/24.</p> <p>Review of facility provided document dated 7/22/24, indicated: Conclusion - event was found as substantiated and NA Employee E1 will be terminated from the facility related to neglect.</p> <p>Interview on 8/20/24, at 1:45 p.m. the Nursing Home Administrator confirmed that the facility failed to protect residents from physical neglect for one of three residents reviewed (Resident R1).</p> <p>28 Pa Code: 201.14 (a) Responsibility of Management</p> <p>28 Pa Code: 201.18 (e)(1) Management.</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> <p>28 Pa. Code 201.29(d) Resident Rights</p>		

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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from the wrongful use of the resident's belongings or money.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46336</p> <p>Based on review of clinical records and facility provided documents, and staff interviews, it was determined that the facility failed to ensure that residents were free from misappropriation (the act of stealing something that you have been trusted to care of and using it for yourself) of medications for two of five residents reviewed (Residents R2 and Resident R3).</p> <p>Findings include:</p> <p>Review of the facility policy Abuse, Neglect, Exploitation and Misappropriation Prevention Program dated, 5/12/24, indicated residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. The objective is to protect residents from abuse, neglect, exploitation, or misappropriation of property by anyone to include facility staff.</p> <p>Review of the facility policy Controlled Substances dated 5/12/24, indicated controlled substances are reconciled upon receipt, administration, disposition, and at the end of each shift. The nurse administering the medication must record it and sign. Medications that are opened and subsequently not given (refused/partially given) are destroyed. Waste and/or disposal of controlled medication are done in the presence of the nurse and a witness who also signs the disposition sheet.</p> <p>Review of admission record indicated Resident R2 was admitted to the facility on [DATE].</p> <p>Review of Resident R2's Minimum Data Set (MDS- a periodic assessment of care needs) dated 7/17/24, indicated the diagnoses of heart failure (heart doesn't pump blood as well as it should), diabetes (a long-term condition in which the body has trouble controlling blood sugar and using it for energy), and chronic obstructive pulmonary disease (COPD- a group of diseases that block airflow and make it hard to breathe).</p> <p>Review of Resident R2's current physician orders on 8/20/24, indicated Oxycodone 30 mg (milligrams) every six hours as needed for pain.</p> <p>Review of admission record indicated Resident R3 was admitted to the facility on [DATE].</p> <p>Review of Resident R3's MDS dated [DATE], indicated the diagnoses of heart failure, diabetes, and cirrhosis (chronic liver damage leading to scarring and liver failure).</p> <p>Review of Resident R3's current physician orders on 8/20/24, indicated Oxycodone 10 mg every four hours as needed for pain.</p> <p>Review of facility provided document dated 7/22/24, indicated it was brought to administration's attention on 7/22/24, that a possible drug diversion has occurred involving Registered Nurse (RN) Employee E7 several lines either not signed out or marked dropped and not co-signed as destroyed which led to suspicion. Investigation conducted indicated six doses of oxycodone were diverted by RN Employee E7.</p> <p>(continued on next page)</p>		

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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of facility provided document dated 7/22/24, indicated it was brought to administration's attention on 7/22/24, that a possible drug diversion has occurred involving Registered Nurse (RN) Employee E7 several lines marked dropped and not co-signed as destroyed, also Resident R3 usually takes one pill at bedtime, and this nurse gave three pills within 12 hours which lead to suspicion. Investigation conducted indicated six doses of oxycodone were diverted by RN Employee E7.</p> <p>Review of RN Employee E7's Employment file indicated a hire date of 6/17/24, and a termination date of 7/23/24 for misappropriation of resident medications.</p> <p>Interview with the Director of Nursing on 8/20/24, at 1:45 p.m. confirmed the narcotics could not be accounted for and that the facility failed to ensure that residents were free from misappropriation of medications for two of five residents reviewed (Residents R2 and Resident R3).</p> <p>28 Pa Code: 201.14 (a) Responsibility of Management</p> <p>28 Pa Code: 201.18 (e)(1) Management.</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> <p>28 Pa. Code 201.29(d) Resident Rights</p>		