STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395790	A. Building B. Wing	09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Seneca Place	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)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35785 Based on review of facility policy, closed clinical records and staff interview, it was determined that the facility failed to notify a medical provider of a change in condition for one out of five closed resident records (Closed Resident Record CR1). Findings include: Review of facility policy Change in a resident's condition or status dated 5/18/24, indicated that the facility promptly notifies the resident, his or her attending physician, and the resident representative of changes in the resident's medical, mental condition or status. Policy Interpretation and Implementation includes: The nurse will notify the resident's physician when there has been: a. accident or incident involving the resident. b. discovery of injuries of an unknown source. c. adverse reaction to medication. d. significant change in the resident's physical/emotional/mental condition. A significant change of condition is a major decline or improvement in the resident's status that will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions, impacts more than one area of the resident's health status, requires interdisciplinary review and/or revision to the care plan; and ultimately is based on the judgment of the clinical staff and the guidelines outlined in the Resident Assessment Instrument. Prior to notifying the physician or healthcare provider, the nurse will make detailed observations and gather relevant and pertinent information for the provider, Review of facility policy Charting and Documentation dated 5/18/24, indicated all services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional, or psychosocial condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Closed Resident Record CR1's admission record indicated he was admitted on [DATE]. Review of Closed Resident Record CR1's Minimum Data Set assessment (MDS - a periodic assessment of care needs) dated 6/10/24, indicated that he had diagnoses that included chronic kidney disease (a loss of kidney function resulting in the swelling of feet, fatigue, high blood pressure and changes in urination), anxiety disorder (a medical condition creating a sense of acute fear, restlessness, and worry), seizure disorder, congestive heart failure (a progressive heart disease affecting pumping action of the heart muscles impacting circulation, swelling and shortness of breath), hypertension (a condition impacting blood circulation through the heart related to poor pressure), and diabetes (metabolic disorder impacting organ function related to glucose levels in the human body). These were some of the most recent diagnoses upon review. Review of Closed Resident Record CR1's care plan dated 6/14/24, indicated to monitor, document, report if complaint is a significant change from residents past experience of pain. Review of Closed Resident Record CR1's physician assistant documentation dated 7/19/24, indicated that Resident CR1 was seen, and he had a history of chronic pain. Resident CR1 was eager to discharge. He complained of back, neck, and shoulder pain. Review of Closed Resident Record CR1's clinical progress note dated 9/1/24 indicated the following: the resident had requested Oxycodone 5mg by mouth at 4:33 a.m. for pain and it was administered at that time. Licensed Practical Nurse (LPN) Employee E1 went back into his room around 4:45 a.m. when he stated he wanted to see the nurse. Licensed Practical Nurse (LPN) Employee E1 explained that he just had medicine and it needed time to work. Nurse talked to him to de-escalate his anxiety or worrying. Closed Resident Record CR1 expressed he felt calmer and less anxious just by talking to the nurse. He wasn't in any respiratory distress at that time. At 5:54 a.m. he went back asleep. Abdomen and chest rising with each breath. His blood sugar was 188. Skin was warm/dry. Review of Closed Resident Record CR1's clinical nurse progress notes dated 9/1/24 did not indicate location of pain, severity of pain, if the pain was new, a discussion with the physician or other clinical staff related to Closed Resident Record CR1's change in status, or a full set of vitals after the onset of chest pain. Nurse aide (NA) Employee E2's signed investigation statement dated 9/3/24, indicated that Closed Resident Record CR1 had some chest pains. Licensed Practical Nurse (LPN) Employee E1 spoke with Closed Resident Record CR1 for 20 minutes. Closed Resident Record CR1 was complaining about his roommate and anxiety related to roommate keeping him awake. He was last checked between 4:00 a.m. and 5:00 a.m. and was sleeping. During an interview on 9/11/24, at 1:08 p.m. Licensed Practical Nurse (LPN) Employee E3 stated that she was familiar with Closed Resident Record CR1, and she was unaware of any heart issues. He would complain of pain in his legs and lower back. And if any resident would complain of chest pain, we would obtain vitals. Anything off the baseline, we would do vitals and notify the doctor. During an interview on 9/11/24, at 1:27 p.m. Licensed Practical Nurse (LPN) Employee E5 stated that he was familiar with Closed Resident Record CR1 and took care of him one year ago. In general, if a resident has chest pain, staff takes vitals signs and notifies the doctor. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 9/11/24, at 1:37 p.m. Licensed Practical Nurse (LPN) Employee E1 provided the following statement: I was there until 7:30 a.m. on 9/1/24. Prior to administering his oxycodone. Closed Resident Record CR1, he was aware he had oxycodone for pain medication, and he would request many times before the 12hrs was up. I went into the MAR (Medication Administration Record) to see the last time Closed Resident Record CR1 was medicated. He asked for the oxycodone, and he told a nurse aide, I cannot recall nurse aide name, he put his call light on , requested medication and he wanted pain medication. I go to look and since I had been there at 7:00 p.m. I looked to make sure 12-hours went by. I went to ask Closed Resident Record CR1 and that is what he wanted medication and not Tylenol. Closed Resident Record CR1 stated he wanted Oxycodone as it was more than 12-hours since he last had it. He took his medication. I asked what his pain was and Closed Resident Record CR1 said he was having pain. He thanked me for getting his medication. He told me what the pain level was. Closed Resident Record CR1 said chest pain and he was lying on his left side. He does have anxiety and the roommate gets up and down and turns on the light. He said he could not sleep and gets worried about the man next to him. I repositioned him and so Closed Resident Record CR1 could take his medication. He did not appear to be in any distress. I listened to his lungs. Lungs were clear and his heart was not irregular. He did not have any order for Nitro (Nitroglycerin-mediation to treat chest pain). Angina was not one of his diagnoses. I cannot recall how much time lapse afterwards. But the aide said Closed Resident Record CR1 was still complaining. I went back to speak to him. He was speaking to me about the resident/roommate. When speaking to Closed Resident Record CR1, he did not feel the medicine was working. I told him the medication will take time to work. It's a strong medicine. I offered him fluids and repositioned him. I spoke to him, and he felt he was calming down. He said he was upset with his roommate. I did explain to the resident and understanding of the situation. And then he was fine. And there were no other further complaints. He did get other medications around 6:00 a.m. and did get his blood sugar checked. He received Depakote and medication for GERD. As a nursing measure, I looked and saw he was breathing. I did not go back and do a detailed note, I probably should have. During a phone interview on 9/12/24, at 11:49 a.m. Nurse aide (NA) Employee E2 provided the following statement: Closed Resident Record CR1 goes to bathroom by himself. He only rings if he needs his medication or more water. On 9/1/24, he had rung around 2:30 a.m. I thought it was weird. He usually does not ask for pain pills. He did not tell me what it was for. I told the Licensed Practical Nurse (LPN) Employee E1. I guess she gave it to him. He called me back about 45-60 minutes later. When Closed Resident Record CR1 called me back in, he told me that the pain pill was not working and that he had got it for chest pain and his chest was still hurting. She, the nurse, told him that he got his pain medication and that he should normally feel it. She stated his pain was from anxiety. Licensed Practical Nurse (LPN) Employee E1 did not due vitals, did not call doctor, and did not tell the RN supervisor. Licensed Practical Nurse (LPN) Employee E1 did not see him with a vital machine. I provided a statement. I was not there when he was found. I was very familiar with him. He never once complained about chest pain. He was continent and aware of his surroundings. He was not the type to hit the call bell over and over. During an interview on 9/12/24 at 2:03 p.m. the Director of Nursing (DON) confirmed that the facility failed to notify a medical provider of a change in condition for Closed Resident Record CR1 as required. 28 Pa. Code 201.14(a) Responsibility of Licensee.