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	07/12/2024

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46167 Based on a review of facility policy, clinical record review, observations, and resident, family and staff interviews, it was determined that the facility failed to provide privacy during medication administration for one of five residents (R51), failed to provide an environment that maintained and enhanced each resident's quality of life for one of two residents (Resident R75), and failed to treat resident with respect by failing to address a resident by their preferred name for one of three residents (Resident R93). Findings include: Review of facility policy Dignity dated 5/18/24, indicated that each resident shall be cared for in a manner that promotes and enhances his or her sense of well- being, level of satisfaction with life, and feelings of self-worth and self-esteem. Residents are treated with dignity and respect at all times. Demeaning practices and standards of care that compromise dignity is prohibited. Staff are expected to promote dignity and assist residents. Review of facility policy Resident Rights dated 5/18/24, indicated that employees shall treat all residents with kindness, respect, and dignity which includes providing privacy and confidentiality. Review of facility policy Translation and/or Interpretation of Facility Services dated 5/18/24, indicated that the facility's language access program will ensure that individuals with limited English proficiency (LEP) shall have meaningful access to information and services provided by the facility. It is understood that providing meaningful access to services provided by this facility requires also that the LEP resident's needs and questions are accurately communicated to the staff. Oral interpretation services therefore included interpretation from the LEP resident's primary language back to English. It is understood that in order to provide meaningful access to services provided by this facility, translation and/or interpretation must be provided in a way that is culturally relevant and appropriate to the LEP individual. Review of the clinical record indicated that Resident R51 was admitted to the facility on [DATE]. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident R51's Minimum Data Set (MDS - periodic assessment of care needs) dated 5/2/24, indicated diagnoses of hypertension (high blood pressure in the arteries), diabetes (a metabolic disorder in which the body has high sugar levels for prolonged periods of time), and cerebral infarction (necrotic tissue in the brain resulting loss of blood and oxygen to the brain). Section K0520, Nutritional Approaches indicated feeding tube (a tube inserted through the wall of the abdomen into the stomach and can be used to provide liquid food, medication, or liquids). During an observation on 7/10/24, at 8:15 a.m. Resident R51 was given medication through a feeding tube with a housekeeper standing at the foot of resident ' s bed in his room. During an interview on 7/10/24, at 8:20 a.m. Registered Nurse Employee E14 stated I did not ask the housekeeper to leave before I gave resident his medication. Review of Resident R51's physician orders on 7/10/24, at 8:45 a.m. indicated: Aspirin 81 mg one time a day for coronary artery disease (damage or disease in the heart's major blood vessels) Duloxetine 30 mg one time a day for depression Flomax 0.4mg one time a day for Urinary Retention Repaglinide 1 mg three times a day for Diabetes FiberLaxative one tab one time a day for supplement Losartan Potassium 50 mg one time a day for hypertension Metoprolol 50 mg twice a day for hypertension During an interview on 7/10/24, at 3:15 p.m. Director of Nursing confirmed that the facility failed to provide privacy during medication administration for one of five residents (R51). Review of the clinical record indicated that Resident R75 was admitted to the facility on [DATE]. Review of Resident R75's MDS dated [DATE], indicated diagnoses of hypertension, heart failure (a progressive heart disease that affects pumping action of the heart muscles), and anemia (too little iron in the body causing fatigue). Section A1110 Language stated preferred language is Spanish. During an attempted interview on 7/8/24, at 9:30 a.m. with Resident R75 indicated resident speaking in a different language other than English when asked a question. During an observation on 7/8/24 through 7/12/24, Resident R75 was unable to communicate in a language that could be understood by staff. Review of Resident R75's plan of care failed to include a communication care plan with obtainable goals and interventions related to Resident R75's language barrier. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 7/8/24, at 1:28 p.m. Licensed Practical Nurse Employee E14 stated that Resident R75's son and daughter visit every day. When they are not in the facility, she uses common signs like pointing to belly and I show her medications to her. I can't understand her though. During an interview on 7/8/24, at 2:38 p.m. Nurse Assistant (NA) Employee E25 stated I have never been assigned to take care of Resident R75 however if I would have to care for her, I would need help to communicate with her. During an interview on 7/8/24, at 2:39 p.m. NA Employee E26 stated I understand a little Italian and Spanish but don ' t speak it. Sometimes she will point to something but I ' m not really sure if she understands, and I don ' t understand what she says back. During an interview on 7/8/24, at 2:42 p.m. NA Employee E27 stated I understand Spanish a little but no Italian. I try to use gestures with her. I know what bathroom means. She was speaking Italian and pointed to her neck. I asked her if she is in pain, and she stated Yes in Spanish. I don't know if she understood that I asked her if she is in pain. Her roommate helps a little. If we had a translator, it would be great, so I don't get confused about what she wants. We can only use personal phones to help with translation. There is no translation device that we can use for her. During an interview on 7/10/24, at 9:10 a.m. Registered Nurse Employee R28 stated I point and tell her what medication I give her. Sometimes I wait to give her medication until her son gets here at noon. He kind of plays the [NAME]. I never seen any equipment in her room to help communicate with her. During an interview on 7/12/24, at 2:10 p.m. Resident R75's Representative stated Me and my sister are the only ones that can communicate with her because she mixes Italian with Spanish. Every time staff have a problem, they call me because I only live fifteen minutes from here. When she was at an acute hospital they had a translator for her. She doesn't understand the English language. During an interview on 7/8/24, at 3:15 p.m. the Director of Nursing confirmed that the facility failed to provide an environment that maintained and enhanced each resident's quality of life by failing to provide readily accessible interpretive services for a limited English proficiency resident. Review of clinical record revealed that Resident R93 was admitted to the facility on [DATE]. Review of Resident 93's MDS (Minimum Data Set, periodic assessment of resident care needs) dated 5/11/24, indicated diagnoses of high blood pressure, chronic kidney disease, and hyponatremia (low sodium level in the blood). Section A1300 D under the question Name by which resident prefers to be addressed, was left blank. During an interview on 7/8/24, at 1:12 p.m. when State Agency asked Resident R93 what name she preferred to be called, Resident R93 stated her preferred name and added that no staff members refer to her by her preferred name and have not asked her what name she prefers. During an interview on 7/10/24, at 2:02 p.m. Social Service Director Employee E5 confirmed that Resident R93's preferred name choice was not documented, and the facility failed to ensure that the facility respected Resident R93's preferences in her name choice. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	28 Pa. Code: 201.29(j) Resident rights.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48546 Based on review of facility policy, observations, and staff interview, it was determined that the facility failed to accommodate the call bell needs for one of five residents (Resident R38). Findings include: Review of facility policy Call System, Resident dated 5/18/24, indicated residents are provided with a means to call staff for assistance through a communication system that directly calls a staff member or a centralized work station. Each resident is provided with a means to call staff directly for assistance from his/her bed, from toileting/bathing facilities and from the floor. The resident call system remains functional at all times. Review of the clinical record indicated Resident R38 was admitted to the facility on [DATE]. Review of Resident R38's Minimum Data Set (MDS - a periodic assessment of care needs) dated 4/7/24, indicated diagnoses of high blood pressure, muscle wasting, and dementia (a group of symptoms that affects memory, thinking and interferes with daily life). During an observation on 7/8/24, at 10:16 a.m. Resident R38 was observed lying in bed with her call bell placed at the top of the mattress, behind her pillow, completely out of the resident's visual sight and reach. During an interview on 7/8/24, at 10:18 a.m. Licensed Practical Nurse Employee E1 confirmed Resident R38's call bell was not accessible and unavailable for use to the resident. During an interview on 7/8/24, at 3:05 p.m. the Director of Nursing confirmed that the facility failed to accommodate the call bell needs for one of five residents (Resident R38). 28 Pa. Code: 201.29(j) Resident rights. 28 Pa. Code: 211.10(d) Resident care policies. 28 Pa. Code: 211.12(d)(3)(5) Nursing services.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46167 Based on review of facility policy, clinical records, and staff interview, it was determined that the facility failed to provide the opportunity to formulate an advance directive (a written instruction such as a living will or durable power of attorney for health care for when the individual is incapacitated) for one of three residents reviewed (Resident R43). Review of the facility policy Advanced Directives, dated 5/18/24, indicated that upon admission, the resident will be provided with written information concerning the right to refuse or accept medical or surgical treatment and to formulate an advanced directive if he or she chooses to do so. Information about whether or not the resident has executed an advanced directive shall be displayed prominently in the medical chart. Review of the clinical record revealed that Resident R43 was admitted to the facility on [DATE]. Review of Resident 43's MDS dated [DATE], indicated diagnoses of quadriplegia (paralysis of all four limbs), high blood pressure, and dry eyes. Review of clinical record conducted on 7/10/24 failed to reveal any documentation that Resident R43 was offered an opportunity to complete Advanced directives During an interview on 7/10/24, at 1:52 p.m. Social Worker Director Employee E5 confirmed that the clinical record did not include documentation that Resident R43 was afforded the opportunity to formulate Advanced Directives. 28 Pa. Code: 201.29(b)(d)(j) Resident rights.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48546 Based on review of facility policy, observation, and staff interview it was determined that the facility failed to maintain the confidentiality of residents' medical information on one of three nursing units (Third Floor) and two of nine residents (Resident R9 and R285). Findings include: Review of facility policy Confidentiality of Information and Personal Privacy dated 5/18/24, indicated the facility will safeguard the personal privacy and confidentiality of all resident personal and medical records. Access to resident personal and medical records will be limited to authorized staff and business associates. During an observation on 7/8/24, at 12:21 p.m. the Third Floor [NAME] Medication Cart at the nurse's station was left unattended with the computer screen open with identifiable information any passerby could see resident personal and confidential information. During an interview on 7/8/24, at 12:24 p.m. Licensed Practical Nurse (LPN) Employee E2 confirmed the above observation. During an interview on 7/8/24, at 3:05 p.m. the Nursing Home Administrator confirmed that the facility failed to maintain the confidentiality of residents' medical information on one of three nursing units (Third Floor). Review of the clinical record indicated that Resident R9 was admitted to the facility on [DATE]. Review of Residents R9's Minimum Data Set (MDS - a periodic assessment of care needs) dated 5/8/24, indicated diagnoses of multiple sclerosis (a potentially disabling disease of the brain and spinal cord (central nervous system), depression, and osteoarthritis (occurs when the protective cartilage that cushions the ends of the bones wears down over time.) Review of Resident R9's physician order dated 2/7/24, indicated to apply a splint with left hand palm protector at all times, remove for hygiene and skin checks. During an observation on 7/10/24, at 9:46 a.m. a sign was observed posted on the resident's wall and bed that stated the resident is to have boots on at all times (AAT) please remove for bathing and put back on after bathing, blue wedge with strap between lower legs to prevent crossing of ankles left palm guard. During an interview on 7/10/24, at 9:47 a.m. Registered Nurse, Employee E4 confirmed the facility failed to maintain the confidentiality of Resident R9's medical information. Review of the clinical record indicated that Resident R285 was admitted to the facility on [DATE]. (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Residents R285's MDS dated [DATE], indicated the diagnoses of respiratory failure (not enough oxygen in the blood) and heart failure (a progressive heart disease that affects pumping action of the heart muscles, which causes fatigue and shortness of breath.). Review of Resident R285's physician order dated 6/23/24, indicated the resident requires a pureed (a smooth, creamy substance or thick liquid suspension) texture, mildly thick consistency regular diet. During an observation on 7/8/24, at 10:24 a.m. a sign was observed posted on the wall behind Resident R285's bed that stated Nectar Thick. During an interview on 7/8/24, at 10:26 a.m. Licensed Practical Nurse, Employee E14 confirmed the facility failed to maintain the confidentiality of Resident R285's medical information. 28 Pa. code: 211.5(b) Clinical records. 28 Pa. Code: 201.29(i) Resident Rights. 28 Pa. Code: 211.12(d)(3) Nursing Services.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46337 Based on review of facility policy, grievance records, reports submitted to the state, and staff interviews, it was determined that the facility failed to implement the facility abuse and neglect policy for two of four allegations (Resident R15 and Resident R38). Findings include: Review of facility policy Abuse, Neglect, Exploitation or Misappropriation- Reporting and Investigating dated 5/18/24, indicated all reports of resident abuse, neglect, exploitation, or theft, misappropriation of resident property are reported to local, state, and federal agencies and thoroughly investigated by facility management. Findings of all investigations are documented and reported. If abuse or neglect is suspected, the suspicion must be reported immediately to the administrator and to other officials according to state law. Immediately is defined as: * within two hours of an allegation involving abuse or results in serious bodily injury; or * within 24 hours of an allegation that does not involve abuse or result in serious bodily injury. Review of Title 42 Code of Federal Regulations (CFR) S483.12(c) states in response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. Review of the clinical record indicated Resident R15 was admitted to the facility on [DATE], and readmitted [DATE]. Review of Resident R15's Minimum Data Set (MDS - a periodic assessment of care needs) dated 4/30/24, indicated diagnoses of quadriplegia (paralysis of all four limbs), aphasia (difficulty speaking), and anxiety. Review of facility provided grievance dated 7/9/24, at 12:04 p.m. indicated the facility was notified that Resident R15 wanted to get out of bed before breakfast and was not gotten out of bed before lunch. A review of incidents submitted to the State on 7/11/24, at 12:50 p.m. did not include the neglect allegation involving Resident R15. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/12/24, at 8:31 a.m. the Director of Nursing (DON) and Nursing Home Administrator (NHA) confirmed Resident R15's allegation of neglect was not reported within 24 hours. Review of the clinical record indicated Resident R38 was admitted to the facility on [DATE]. Review of Resident R38's MDS dated [DATE], indicated diagnoses of high blood pressure, anxiety, and blindness in one eye. During a review of facility provided grievances on 7/11/24, at 10:24 a.m. revealed an allegation of neglect for Resident R38 that was submitted by resident's daughter on 7/4/24. During a review of the facility provided grievances on 7/11/24, at 10:35 a.m. revealed an allegation of neglect for Resident R38. The grievance completed states that her daughter visited Resident R38 on 7/4/24, at 1:55 p.m. and stated mom's cold, untouched lunch tray was still on bedside. Resident R38's daughter stated If I hadn't shown up, mom would not have eaten. Mom needs help eating and no one helped or fed her. She ate a lot and even ate her snacks later that was provided with my assistance and mom reeked of urine and her roommate's clothing and bedding were filthy with spilled meals and drinks. These women were not taken care of properly today. The aide was neglectful of her duties. During a review of a witness statement on 7/11/24, at 10:45 a.m. revealed that Resident R38's daughter spoke with Unit Manager Employee E22 on 7/4/24, at 3:00 p.m. Employee E2 wrote The resident wasn't rounded on all day. I kept telling the aide to do her rounds. She came in at 8:15 a.m., and was seen sitting in different areas on the floor instead of doing her rounds. A review of incidents submitted by the facility to the State Agency on 7/11/24, at 12:45 p.m., did not include the neglect allegation involving Resident R38. During an interview on 7/11/24, at 12:50 p.m. the Nursing Home Administrator (NHA) stated that she followed up on this grievance and we just figured there were other staff on the floor that day and we just thought that she would have been cared for. The aide is on the DNR (Do not return) list. During an interview on 7/11/24, at 12:53 p.m. the NHA confirmed that a thorough investigation was not completed or reported and they will get the report submitted today. During an interview on 7/11/24, at 12:58 p.m. the NHA confirmed that the facility failed to report an allegation of abuse or neglect in the required timeframe and failed to implement the facility abuse and neglect policy for two of four allegations (Resident R15 and Resident R38). 28 Pa Code: 201.14 (a) Responsibility of Management 28 Pa Code: 201.18 (e)(1) Management.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45577 Based on review of facility policy, facility grievances, reports submitted to the State, and staff interviews, it was determined that the facility failed to report an allegation of abuse or neglect for one of four residents (Resident R38). Findings include: Review of facility policy Abuse, Neglect, Exploitation or Misappropriation- Reporting and Investigating dated 5/18/24, indicated all reports of resident abuse, neglect, exploitation, or theft, misappropriation of resident property are reported to local, state, and federal agencies and thoroughly investigated by facility management. Findings of all investigations are documented and reported. If abuse or neglect is suspected, the suspicion must be reported immediately to the administrator and to other officials according to state law. Immediately is defined as: - within two hours of an allegation involving abuse or result in serious bodily injury; or - within 24 hours of an allegation that does not involve abuse or result in serious bodily injury. Review of Title 42 Code of Federal Regulations (CFR) S483.12(c) states in response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. Review of the clinical record indicated Resident R38 was admitted to the facility on [DATE]. Review of Resident R38's Minimum Data Set (MDS - a periodic assessment of care needs) dated 1/25/24, indicated diagnoses of high blood pressure, anxiety, and blindness in one eye. During a review of facility provided grievances on 7/11/24, at 10:24 a.m. revealed an allegation of neglect for Resident R38 that was submitted by resident's daughter on 7/4/24. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility provided grievances on 7/11/24, at 10:35 a.m. revealed an allegation of neglect for Resident R38. The grievance completed states that her daughter visited Resident R38 on 7/4/24, at 1:55 p.m., and stated mom's cold, untouched lunch tray was still on bedside. Resident R38's daughter stated If I hadn't shown up, mom would not have eaten. Mom needs help eating and no one helped or fed her. She ate a lot and even ate her snacks later that was provided with my assistance and mom reeked of urine and her roommate's clothing and bedding were filthy with spilled meals and drinks. These women were not taken care of properly today. The aide was neglectful of her duties. During a review of a witness statement on 7/11/24, at 10:45 a.m. revealed that Resident R38's daughter spoke with Unit Manager Employee E22 on 7/4/24, at 3:00 p.m. Employee E2 wrote The resident wasn't rounded on all day. I kept telling the aide to do her rounds. She came in at 8:15 a.m., and was seen sitting in different areas on the floor instead of doing her rounds. A review of incidents submitted to the State on 7/11/24, at 12:45 p.m., did not include the neglect allegation involving Resident R38. During an interview on 7/11/24, at 12:50 p.m. the Nursing Home Administrator (NHA) stated that she followed up on this grievance and we just figured there were other staff on the floor that day and we just thought that she would have been cared for. The aide is on the DNR (Do not return) list. During an interview on 7/11/24, at 12:53 p.m. the NHA confirmed that a thorough investigation was not completed or reported and they will get the report submitted today. During an interview on 7/11/24, at 12:58 p.m. the NHA confirmed that the facility failed to report an allegation of abuse or neglect for one of four residents in a timely manner, as required (Resident R38). 28 Pa Code: 201.14 (a) Responsibility of Management 28 Pa Code: 201.18 (e)(1) Management.

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	07/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Seneca Place	5360 Saltsburg Road Verona, PA 15147

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45577 Based on review of facility policy, facility grievances, investigation documentations, and staff interviews, it was determined that the facility failed to conduct a thorough investigation involving an allegation of neglect for one out of four residents (Resident R38). Findings include: Review of facility policy Abuse, Neglect, Exploitation or Misappropriation- Reporting and Investigating dated 5/18/24, indicated all reports of resident abuse, neglect, exploitation, or theft, misappropriation of resident property are reported to local, state, and federal agencies and thoroughly investigated by facility management. Findings of all investigations are documented and reported. If abuse or neglect is suspected, the suspicion must be reported immediately to the administrator and to other officials according to state law. Immediately is defined as: - within two hours of an allegation involving abuse or result in serious bodily injury; or - within 24 hours of an allegation that does not involve abuse or result in serious bodily injury. Review of Title 42 Code of Federal Regulations (CFR) S483.12(c) states in response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. Review of the clinical record indicated Resident R38 was admitted to the facility on [DATE]. Review of Resident R38's Minimum Data Set (MDS - a periodic assessment of care needs) dated 1/25/24, indicated diagnoses of high blood pressure, anxiety, and blindness in one eye. During a review of facility provided grievances on 7/11/24, at 10:24 a.m. revealed an allegation of neglect for Resident R38 that was submitted by resident's daughter on 7/4/24. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility provided grievances on 7/11/24, at 10:35 a.m. revealed an allegation of neglect for Resident R38. The grievance completed states that her daughter visited Resident R38 on 7/4/24, at 1:55 p.m. and stated mom's cold, untouched lunch tray was still on bedside. Resident R38's daughter stated If I had not shown up, mom would not have eaten. Mom needs help eating and no one helped or fed her. She ate a lot and even ate her snacks later that was provided with my assistance and mom reeked of urine and her roommate's clothing and bedding were filthy with spilled meals and drinks. These women were not taken care of properly today. The aide was neglectful of her duties. During a review of a witness statement on 7/11/24, at 10:45 a.m., revealed that daughter spoke with Unit Manager Employee E22 on 7/4/24, at 3:00 p.m. Employee E2 wrote, The resident was not rounded on all day. I kept telling the aide to do her rounds. She came in at 8:15 a.m. and was seen sitting in different areas on the floor instead of doing her rounds. A review of incidents submitted to the State on 7/11/24, at 12:45 p.m. did not include the neglect allegation involving Resident R38. During an interview on 7/11/24, at 12:50 p.m. the Nursing Home Administrator (NHA) stated that she followed up on this grievance and we just figured there were other staff on the floor that day and we just thought that she would have been cared for. The aide is on the DNR (Do not return) list. During an interview on 7/11/24, at 12:53 p.m. the NHA confirmed that a thorough investigation was not completed or reported, and they will get the report submitted today. During an interview on 7/11/24, at 12:58 p.m. the NHA confirmed the facility failed to complete a thorough investigation to rule out abuse and neglect as required for one out of four residents (Resident R38). 28 Pa Code: 201.18 (e)(1)(2) Management 28 Pa Code: 201.29 (a)(c)(d) Resident Rights 28 Pa Code: 211.12 (a)(c)(d)(1)(3)(5) Nursing services

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45577 Based on review of facility policies, resident records and staff interview, it was determined that the facility failed to acquire and document a physician's discharge order for one out of three resident records (Resident R133) reviewed, and failed to make certain that the necessary resident information was communicated to the receiving health care provider for five out of six residents sampled with facility initiated transfers (Residents R28, R43, R64, R75, and R83). Finding include: The facility Discharge Summary and Plan policy dated 5/18/24, indicated that when a resident's discharge is anticipated, a discharge summary and post-discharge plan will be developed to assist the resident to adjust to his/her new living environment. The discharge summary will include a recapitalization of the resident's stay at this facility and a final summary of the resident's status at the time of discharge in accordance with established regulations governing release of resident information and as permitted by the resident. Review of the facility policy Transfer Form dated 5/18/24, indicated that should it become necessary to transfer a resident from the facility, a Transfer Form will be executed and forwarded with the resident. The Transfer Form will be completed by Nursing Service and will include: Current medical findings Diagnosis Medications at time of discharge Rehabilitative potential Nursing/dietary information ADL (activities of daily living) function Ambulation status Summary of the course of treatment followed Basis for the transfer Contact information of the practitioner responsible for the care of the resident Resident representative information including contact information Advanced Directive information (continued on next page)

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	395790	A. Building B. Wing	07/12/2024

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	All special instructions or precautions for ongoing care Comprehensive care plan goals All other necessary information, including a copy of the residents discharge summary, and any other documentation A copy of the Transfer Form will be filed in the resident's medical record. Review of the clinical record indicated that Resident R28 was admitted to the facility on [DATE]. Review of Resident 28's Minimum Data Set (MDS - a periodic assessment of care needs) dated 5/8/24, indicated diagnoses of muscle weakness, high blood pressure, and diabetes. Review of clinical record revealed that Resident R28 was sent out to the hospital on 6/29/24,at 10:57 a.m. and returned to the facility on [DATE], at 5:40 p.m Review of Resident R28's clinical record revealed no documented evidence that the facility had communicated specific information to the receiving health care provider for the residents transferred and expected to return, which included the resident's care plan goals, advanced directive information, specific instructions for ongoing care, resident representative information, and all information necessary to meet the resident's specific needs at the receiving facility. Review of the clinical record indicated that Resident R43 was admitted to the facility on [DATE]. Review of Resident 43's MDS dated [DATE], indicated diagnoses of quadriplegia (paralysis of all four limbs), high blood pressure, and dry eyes. Review of clinical record revealed that resident was sent out to the hospital on 6/26/24, and returned to the facility on [DATE]. Review of Resident R43's clinical record revealed no documented evidence that the facility had communicated specific information to the receiving health care provider for the residents transferred and expected to return, which included the resident's care plan goals, advanced directive information, specific instructions for ongoing care, resident representative information, and all information necessary to meet the resident's specific needs at the receiving facility. Review of the clinical record indicated that Resident R64 was admitted to the facility on [DATE]. Review of Resident 64's MDS dated [DATE], indicated diabetes, high blood pressure, and cerebral palsy (group of disorders that affect a person's ability to move and maintain balance and posture). Review of clinical record revealed that Resident R64 was sent out to the hospital on 1/27/24 and returned to the facility on [DATE]. (continued on next page)

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	395790	A. Building B. Wing	07/12/2024

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident R64's clinical record revealed no documented evidence that the facility had communicated specific information to the receiving health care provider for the residents transferred and expected to return, which included the resident's care plan goals, advanced directive information, specific instructions for ongoing care, resident representative information, and all information necessary to meet the resident's specific needs at the receiving facility. Review of the clinical record indicated that Resident R75 was admitted to the facility on [DATE]. Review of Resident R75's MDS dated [DATE], indicated diagnoses of high blood pressure, heart failure (a progressive heart disease that affects pumping action of the heart muscles), and anemia (too little iron in the body causing fatigue). Review of clinical record indicated that Resident R75 was sent out to the hospital on 5/16/24, and returned to the facility on [DATE]. Review of Resident R75's clinical record revealed no documented evidence that the facility had communicated specific information to the receiving health care provider for the residents transferred and expected to return, which included the resident's care plan goals, advanced directive information, specific instructions for ongoing care, resident representative information, and all information necessary to meet the resident's specific needs at the receiving facility. Review of the clinical record indicated Resident R83 was admitted to the facility on [DATE]. Review of Resident R83's MDS dated [DATE], indicated diagnoses of high blood pressure, septicemia (a serious infection that occurs when bacteria enter the bloodstream), and dementia (a group of symptoms that affects memory, thinking, and interferes with daily life). Review of the clinical record indicated Resident R83 was transferred to the hospital on 4/16/24 and returned to the facility on [DATE]. Review of Resident R83's clinical record revealed no documented evidence that the facility had communicated specific information to the receiving health care provider for the residents transferred and expected to return, which included the resident's care plan goals, advanced directive information, specific instructions for ongoing care, resident representative information, and all information necessary to meet the resident's specific needs at the receiving facility. During an interview on 7/11/24, at 12:44 p.m. the Director of Nursing (DON) confirmed that there was no evidence that the necessary information was communicated to the receiving health care institution or provider upon transfer for six out of six residents sampled with facility initiated transfers (Residents R28, R43, R51, R64, R75 and R83). Review of the clinical record indicated Resident R133 was admitted to the facility 3/16/24. Review of Resident R133's MDS dated [DATE], indicated diagnosis that included peripheral vascular disease (blood circulation disorder that affects the blood vessels outside the brain and heart), diabetes (endocrine disease that affects how the body uses blood sugar), and hypothyroidism (condition resulting from decrease production of thyroid hormones). (continued on next page)

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	07/12/2024

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident R133's clinical physician progress note dated 4/11/24, indicated that today, she will be returning to her prior Independent Living Facility. Review of Resident R133's clinical progress note dated 4/11/24, indicated that Resident R133 is scheduled for discharge this afternoon with all personal belongings and balance of medications; will proceed with discharge plan per orders. Review of Resident R133's clinical record did not include a physician's order to discharge home from the facility. During an interview on 7/9/24, at 12:52 p.m., the Director of Nursing (DON) confirmed that the facility failed to acquire and document a physician's discharge order for one of three resident records (Resident R133), and failed to make certain that the necessary resident information was communicated to the receiving health care provider for five out of six residents sampled with facility initiated transfers (Residents R28, R43, R64, R75, and R83). 28 Pa. Code 201.29 (a)(c.3)(2) Resident rights.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48546 Based on review of facility policy, clinical record review, and staff interviews, it was determined that the facility failed to make certain that resident assessments were accurate for seven of 23 residents (Resident R2, R6, R21, R38, R64, R68, and R285). Findings include: Review of facility policy Certifying Accuracy of the Resident Assessment, dated 5/18/24, indicated the information captured on the assessment reflects the status of the resident during the observation (look-back) period for that assessment. Review of the clinical record indicated Resident R2 was admitted to the facility on [DATE]. Review of Resident R2's Quarterly Minimum Data Set (MDS - a periodic assessment of care needs) dated 5/26/24, indicated diagnoses of high blood pressure, hemiplegia (paralysis on one side of the body), and muscle weakness. Review of Section GG - Functional Abilities and Goals indicated Resident R2 was coded as 1 dependent upon staff for roll left and right. Review of a physician order dated 2/22/24, indicated the usage of bilateral upper quarter side rails for mobility and positioning every shift. During an observation on 7/12/24, at 11:26 a.m. Licensed Practical Nurse (LPN) Employee E1 confirmed there were bilateral upper side rails on Resident R2's bed. During this observation, LPN Employee E1 stated, Resident R2 is able to use the side rails during bed mobility, he is able to hold on to the bars while care is being provided. Review of Resident R2's MDS - Optional State assessment dated [DATE], Section G - Functional Status, Question G0110 indicated Resident R2 was coded 3 extensive assistance to complete bed mobility. During an interview on 7/12/24, at 12:24 p.m. MDS Coordinator Employee E9 stated, Resident R2 uses the side rails for turning assistance, he should not be coded as dependent on his quarterly MDS. During an interview on 7/12/24, at 12:24 p.m. MDS Coordinator Employee E9 confirmed that the facility failed to make certain Resident R2's resident assessment was accurate. Review of the clinical record indicated Resident R6 was admitted to the facility on [DATE]. Review of Resident R6's MDS dated [DATE], indicated diagnoses of depression, anemia (too little iron in the body causing fatigue), and post traumatic stress disorder (a disorder in which a person has difficulty recovering after experiencing or witnessing a terrifying event). Section P, Restraints and Alarms, MDS was coded 2, side rails used daily. Review of a physician order dated 2/22/24, indicated the usage of bilateral upper quarter side rails for mobility and positioning while in bed. (continued on next page)

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	395790	A. Building B. Wing	07/12/2024

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 7/12/24, at 10:03 a.m. bilateral side rails were observed on bed. Resident R6 stated I use them to help me in bed. During an interview on 7/12/24, at 12:25 p.m. MDS Coordinator Employee E9 confirmed the upper side rails were not being used as a restraint on R6's bed. During an interview on 7/12/24, at 12:27 p.m. MDS Coordinator Employee E9 confirmed there were bilateral upper side rails on Resident R6's bed for positioning. During an interview on 7/12/24, at 12:29 p.m. MDS Coordinator Employee E9 confirmed that the facility failed to make certain Resident R6's resident assessment was accurate. Review of the clinical record indicated Resident R21 was admitted to the facility on [DATE]. Review of Resident R21's MDS dated [DATE], indicated diagnoses of high blood pressure, dementia (a group of symptoms that affects memory, thinking and interferes with daily life), and muscle wasting. Review of Section GG - Functional Abilities and Goals indicated Resident R21 was coded as 2 substantial/maximal assistance from staff for roll left and right. Review of Section P - Restraints and Alarms, Question P0100 indicated Resident R21 was coded as 2 for bed rail used daily. Review of a physician order dated 1/31/24, indicated the usage of bilateral upper side rails. During an observation on 7/8/24 at 10:25 a.m. no side rails were observed on Resident R21's bed. During an interview on 7/12/24, at 12:22 p.m. MDS Coordinator Employee E9 stated, (Resident R21) had his bed switched over the weekend, that's why he does not currently have side rails on his bed. He did previously use the side rails for mobility and positioning, but he has been performing bed mobility well without them. His MDS is coded incorrectly for restraint usage. During an interview on 7/12/24, at 12:22 p.m. MDS Coordinator Employee E9 confirmed that the facility failed to make certain Resident R21's resident assessment was accurate. Review of the clinical record indicated Resident R38 was admitted to the facility on [DATE]. Review of Resident R38's MDS dated [DATE], indicated diagnoses of high blood pressure, dementia, and muscle wasting. Review of Section O - Special Treatments, Procedures, and Programs indicated the Resident R38 was not receiving hospice care during the 14-day assessment period. Review of a physician order dated 1/28/24, indicated to admit Resident R38 to hospice services. During an interview on 7/8/24, at 10:48 a.m. Health Unit Coordinator (HUC) Employee E22 confirmed Resident R38 receives hospice services on Mondays and Wednesdays. During an interview on 7/8/24, at 12:03 p.m. Registered Nurse Assessment Coordinator (RNAC) Employee E7 confirmed Resident R38's resident assessment was not accurately completed to reflect hospice care. Review of the clinical record indicated Resident R64 was admitted to the facility on [DATE]. (continued on next page)

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	395790	A. Building B. Wing	07/12/2024

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident R64's MDS dated [DATE], indicated diagnoses of high blood pressure, diabetes (a metabolic disorder in which the body has high sugar levels for prolonged periods of time), and cerebral palsy (group of disorders that affect a person's ability to move and maintain balance and posture). Section P, Restraints and Alarms, MDS was coded 2, side rails used daily. Review of a physician order dated 3/1/24, indicated the usage of bilateral upper quarter side rails. During an observation on 7/8/24, at 10:10 a.m. bilateral upper side rails were observed on Resident R64's bed. Resident R64 stated I use them to help me move in bed. During an interview on 7/12/24, at 12:25 p.m. MDS Coordinator Employee E9 confirmed the upper side rails were not being used as a restraint on R64's bed. During an interview on 7/12/24, at 12:27 p.m. MDS Coordinator Employee E9 confirmed there were bilateral upper side rails on Resident R64's bed for positioning. During an interview on 7/12/24, at 12:28 p.m. MDS Coordinator Employee E9 confirmed that the facility failed to make certain Resident R64's resident assessment was accurate. Review of the clinical record indicated Resident R68 was admitted to the facility on [DATE]. Review of Resident R68's MDS dated [DATE], indicated diagnoses of high blood pressure, asthma (a condition where the airways narrow and swell), and Post-Traumatic Stress Disorder (PTSD - a disorder in which a person has difficulty recovering after experiencing or witnessing a terrifying event and may have triggers that can bring back memories of trauma accompanied by intense emotional and physical reactions). Review of Section O - Special Treatments, Procedures, and Programs indicated Resident R38 did not receive oxygen therapy during the 14-day assessment period. Review of Resident R68's Oxygen Saturations Summary revealed that the resident had received supplemental oxygen for five days of the 14-day look-back period. Review of Resident R68's care plan dated 5/15/24, indicated the resident has oxygen therapy related to respiratory illness and the resident will have no signs or symptoms of poor oxygen absorption through the review date. During an interview on 7/10/24, at 2:50 p.m. RNAC Employee E7 confirmed Resident R68's resident assessment was not accurately completed to reflect oxygen therapy. Review of the clinical record indicated that Resident R285 was admitted to the facility on [DATE]. Review of Resident R285's MDS dated [DATE], indicated diagnoses of stage 3 pressure ulcer (localized injury to the skinand underlying tissue, as a result of pressure, which involves full thickness tissue loss), anxiety, and dementia. Section M- Skin Conditions indicated the resident had no unhealed pressure ulcers/injuries. Review of Resident R285's progress note dated 6/21/24, at 8:28 p.m. indicated the resident arrived by ambulance to the facility. It was indicated the resident had a stage 3 on the coccyx. (continued on next page)

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	07/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 7/10/24, at 12:01 p.m. RNAC Employee E7 confirmed that the facility failed to make certain Resident R285's resident assessment was accurate. 28 Pa. Code 211.5(f) Clinical records. 28 Pa. Code 211.12(d)(5) Nursing services.

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	395790	A. Building B. Wing	07/12/2024

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46337 Based on review of facility policy, clinical record review, and staff interview, it was determined that the facility failed to timely recheck and notify the physician of decreased Capillary Blood Glucose (CBG) levels for one of three residents (Resident R284). Findings include: Review of facility policy Management of Hypoglycemia dated 5/18/24, indicated if a resident's blood sugar is less than 70 milligrams per deciliter (mg/dl), but greater than 54 mg/dl then give the resident an oral form of rapidly absorbed glucose (15-20 grams). Notify the provider immediately, remain with the resident, and recheck the resident's blood glucose in 15 minutes. It was indicated to document the resident's blood glucose before intervention, note the blood sugar after each administration of rapid-acting glucose and follow-up blood sugar, record the resident's level of consciousness before and after intervention, document provider instructions. Review of the clinical record indicated Resident R284 was admitted to the facility on [DATE], with diagnoses diabetes mellitus (a chronic (long-lasting) health condition that affects how your body turns food into energy), anxiety, and depression. Review of Resident R284's physician order dated 3/1/24, indicated to monitor the resident's blood glucose in the evening for diabetes. Review of Resident R284's care plan dated 5/3/24, indicated the resident has diabetes and interventions included to monitor, document, and report as needed any signs and symptoms of hypoglycemia. Review of Resident R284's Minimum Data Set (MDS - a periodic assessment of care needs) dated 6/17/24, indicated diagnoses diabetes were current. Review of Resident R284's progress note dated 7/8/24, at 9:08 p.m. indicated the resident's blood glucose was 62. Resident R284 was eating a peanut butter and jelly sandwich, it was indicated her blood glucose would be checked after snack. Review of the resident's clinical record failed to indicate the physician was notified, and the resident's blood glucose was rechecked in 15 minutes as per the facility policy. Review of Resident R284's progress note dated 7/8/24, at 11:34 p.m. indicated the resident's blood glucose was 169. The facility failed to timely recheck Resident R284's blood glucose. During an interview on 7/9/24, at 1:35 p.m. Licensed Practical Nurse (LPN), Employee E16 indicated if a resident's blood glucose is less than 70 mg/dl then the hypoglycemia protocol is implemented. It was indicated if the blood glucose is between 50-69 mg/dl then 15 grams of an oral carb such as 4 ounces of apple juice, non-diet soft drink, or three graham crackers are provided to the resident. The resident's blood glucose is then rechecked within 15 minutes, and the physician must be notified by the next business day. It was indicated documentation of notification to the physician, interventions, and any new orders are entered in the resident's clinical record. (continued on next page)

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	07/12/2024

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/9/24, at 1:40 p.m. LPN, Employee E10 stated Resident R284 is a brittle diabetic. LPN, Employee E10 confirmed the facility failed to notify the physician of decreased Capillary Blood Glucose (CBG) levels, and timely recheck Resident R284's blood glucose on 7/8/24. 28 Pa. Code 201.18 (b)(1) Management 28 Pa. Code 201.29(d) Resident Rights 28 Pa. Code 211.10 (c)(d) Resident Care policies 28 Pa. Code 211.12 (d)(1)(2)(3)(5) Nursing services

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46337 Based on review of clinical records, facility policy, observations, and staff interviews, it was determined that the facility failed to provide prescribed treatment and services related to the care of pressure ulcers for four of six residents (Resident R4, R9, R83, R243) that resulted in worsening and new pressure area for one resident (Resident R83) and failed to prevent avoidable pressure ulcer development that of a new pressure ulcer for two of six residents (Resident R9). Findings include: Review of facility policy Prevention of Pressure Injuries, dated 5/18/24, indicated that the facility will conduct a comprehensive skin assessment upon (or soon after) admission with each risk assessment, as indicated according to the resident's risk factors, and prior to discharge. Use a standardized pressure injury screening tool to determine risk factors. Inspect skin on a daily basis when performing or assisting with personal care. Identify any signs of developing pressure injuries. Inspect pressure points sacrum (lower back above the tailbone), heels, buttocks, ischium (the lower and back sides of the hip bone), etc. Prevention includes: Keep the skin clean and hydrated. Clean promptly after episodes of incontinence. Avoid alkaline soaps and cleansers. Use a barrier product to protect skin from moisture. Use incontinence products with high absorbency. Do not rub or otherwise cause friction on skin that is at risk of pressure injuries. Use facility approved protective dressings for at risk individuals. Review of the United States Department of Health and Human Services, Agency for Healthcare Research & Quality's, Safety Program for Nursing Home: On-Time Pressure Ulcer Prevention dated May 2016, indicated that Pressure ulcers cause pain, disfigurement, and increased infection risk and are associated with longer hospital stays and increased morbidity and mortality. Three critical components in preventing pressure ulcers were listed: comprehensive skin assessments, standardized pressure ulcer risk assessments, and care planning and implementation to address areas of risk. Review of the National Library of Medicine, The Braden Scale for Predicting Pressure Sore Risk indicated the scale was developed to foster early identification of patients at risk for forming pressure ulcers. The scale consists of six subscales and the total range from 6-23, with the following distributions: (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Severe Risk: Less than or equal to 9. -High Risk: 10-12. -Moderate Risk: 13-14. -Mild Risk: 15-18. Review of the clinical record indicated that Resident R4 was admitted to the facility on [DATE], and readmitted [DATE], with the diagnoses of end stage kidney disease (a condition where the kidney reaches advanced state of loss of function), dependence on dialysis (a blood purifying treatment given when kidney function is not optimum), and high blood pressure. Review of Resident R4's physician order dated 3/20/24, indicated to complete a skin check weekly every evening shift every Monday for monitoring. Review of R4's physician order dated 4/15/24, indicated to cleanse abdominal wound with antibacterial soap and water, pat dry. Then cleanse with Vashe (wound cleaning solution to prevent bacteria growth), and let dry. Do not rinse. Place full strength Dakins (antibiotic solution that fights bacteria) moistened gauze loosely into the wound and cover with abdominal pad (wound dressing used for wounds requiring high absorbency) and secure with tape daily, every evening shift for wound care. Review of Resident R4's care plan dated 4/28/24, indicated the resident receives wound management. Interventions indicated to measure ulcer on at regular intervals, monitor for signs of declination, and provide wound care treatment as ordered. The care plan failed to identify the wound's location and dressing change order. Review of Resident R4's Minimum Data Set (MDS- a periodic assessment of care needs) dated 5/8/24, indicated the diagnoses were current. Review of a Skin/Wound Note 6/20/24, revealed that the note was entered by Wound Care Nurse Employee E4 on 7/9/24, at 10:21 a.m., 19 days later. Review of a Skin/Wound Note dated 6/27/24, revealed that the note was entered by Wound Care Nurse Employee E4 on 7/9/24, at 10:23 a.m., 12 days later. During an observation and interview on 7/9/24 10:33 a.m. LPN, Employee E16 confirmed Resident R4's dressing to her right lower abdomen was not dated or initialed. During an interview on 7/12/24, at 8:54 a.m. the Director of Nursing confirmed the facility failed to create a resident-centered personalized care plan for Resident R4's wound, and ensure the resident received weekly skin assessments as ordered. Review of the clinical record indicated that Resident R9 was admitted to the facility on [DATE], with diagnoses of multiple sclerosis (a potentially disabling disease of the brain and spinal cord (central nervous system), depression, and osteoarthritis (occurs when the protective cartilage that cushions the ends of the bones wears down over time.) (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident R9's Braden Scale assessment dated [DATE], indicated Resident R9 was at low risk (score of 15) for pressure ulcer development. Review of Residents R9's Minimum Data Set (MDS - a periodic assessment of care needs) dated 2/9/24, Section M: Skin Conditions indicated the resident did not have one or more unhealed pressure ulcers. Review of a physician order dated 2/27/24, indicated to complete a skin check weekly every evening shift every Tuesday for monitoring. Review of Resident R9's progress note dated 3/3/24, entered by Registered Nurse RN, Employee E23 indicated the resident had an open sore on left heel and was slightly bleeding. It was indicated the resident heels were elevated on a pillow and frequent positioning was rendered. Review of Resident R9's Wound Assessment report dated 3/4/24, indicated the resident developed a facility acquired Stage 2 pressure ulcer that measured 2.4 cm x 2.2 cm x 0.1 cm. Review of Resident R9's clinical record failed to include a weekly wound assessment for Resident R9's left heel the week of 4/2/24 and 4/9/24. The facility failed to monitor Resident R9's skin weekly as ordered. Review of Resident R9's progress note dated 4/16/24, entered by Wound Care Nurse, Employee E4 stated This RN in to assess wound measuring 2.0 x 1.5 x 0.2 cm. drainage lessening, pain lessening, very small amount of slough remains, same treatment continues. Wound Care Nurse, Employee E4 failed to indicate that location and stage of the resident's wound. Review of Resident R9's clinical record failed to include a weekly wound assessment for Resident R9's left heel the week of 4/23/24, and 4/30/24. Review of Resident R9's care plan dated 5/6/24, indicated the resident was at risk for impaired skin integrity due to multiple sclerosis. Interventions included to evaluate skin for redness or excoriation, monitor skin for redness specifically over bony prominences, position resident to reduce causes of friction or shear, and perform Braden Scale assessment. Review of Resident R9's progress note dated 5/7/24, entered by Wound Care Registered Nurse, Employee E4 indicated the resident left heel wound measures 1.1 x 0.9. Wound Care Registered Nurse, Employee E4 failed to document the depth and stage of the resident's left heel pressure ulcer. Review of Residents R9's MDS dated [DATE], Section M: Skin Conditions, indicated Resident R9 was at risk of pressure ulcer development, and at the time of the assessment the resident had one Stage three pressure ulcer (full-thickness skin loss potentially extending into the subcutaneous tissue layer). Review of Resident R9's progress note dated 5/16/24, entered by Wound Care Registered Nurse, Employee E4 indicated the resident left heel wound measures 1.3 x 1 cm. Wound Care Registered Nurse, Employee E4 failed to document the depth and stage of the resident's left heel pressure ulcer. The wound increased in size. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident R9's progress note dated 5/21/24, entered by Wound Care Registered Nurse, Employee E4 indicated the resident left heel wound measures 0.8 x 0.8 shows slight greenish drainage. Wound Care Registered Nurse, Employee E4 failed to document the depth and stage of the resident's left heel pressure ulcer. Review of Resident R9's physician order dated 5/28/24, indicated to cleanse the left heel with Vashe (wound cleanser), apply collagen paste (a wound paste that contains protein that plays a role in each phase of wound healing and encourages new tissue growth), mix small amount of normal saline solution with powder to form paste, and cover with abdominal pad (wound dressing used for wounds requiring high absorbency) and kerlix (rolled gauze commonly used to wrap extremity wounds) daily for wound care. Review of Resident R9's progress note dated 5/28/24, entered by Wound Care Registered Nurse, Employee E4 indicated the resident left heel wound measures 0.8 x 0.8, shows scant greenish drainage on dressing. Wound Care Registered Nurse, Employee E4 failed to document the depth and stage of the resident's left heel pressure ulcer. Review of Resident R9's progress note dated 6/4/24, entered by Wound Care Registered Nurse, Employee E4 indicated the resident left heel wound measures 0.8 x 0.8 Wound Care Registered Nurse, Employee E4 failed to document the depth and stage of the resident's left heel pressure ulcer. Review of Resident R9's clinical record failed to indicate a weekly skin assessments was completed for Resident R9's left heel pressure ulcer for the week 6/10/24. Review of Resident R9's progress note dated 6/20/24, entered by Wound Care Registered Nurse, Employee E4 indicated the resident left heel wound measures 0.5 x 0.5. Wound Care Registered Nurse, Employee E4 failed to document the depth and stage of the resident's left heel pressure ulcer. Review of Resident R9's clinical record failed to indicate a weekly skin assessments was completed for Resident R9's left heel pressure ulcer for the week of 7/1/24. Review of Resident R9's Skin and Wound Evaluation V7.0 dated 6/27/24, indicated the resident had a stage 2 pressure ulcer that measured 2.2 cm x 2.1 cm x 1.4 cm. It was indicated the surrounding tissue had black/blue discoloration. It stated the resident's pressure ulcer was almost healed and then the resident developed a Deep Tissue Injury (DTI) on new periwound skin (refers to tissue surrounding a wound). It was indicated the wound was deteriorating. Review of Resident R9's care plan on 7/9/24, at 1:52 p.m. failed to include Resident R9's left pressure ulcer. During an interview on 7/9/24, at 2:50 p.m. the Director of Nursing (DON) confirmed Resident R9 does not have a care plan for his left heel pressure ulcer. Review of the clinical record indicated Resident R38 was admitted to the facility on [DATE]. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident R38's MDS dated [DATE], indicated diagnoses of high blood pressure, dementia (a group of symptoms that affects memory, thinking and interferes with daily life), and muscle wasting. Section M: Skin Conditions indicated Resident R38 was at risk of pressure ulcer development, and at the time of the assessment the resident had one unhealed Stage 3 pressure ulcer. Review of Resident R38's Braden Scale assessment dated [DATE], indicated Resident R39 was at high risk (score 11) for pressure ulcer development. Review of Resident R38's Braden Scale assessment dated [DATE], indicated Resident R38 was at high risk (score 10) for pressure ulcer development. Review of Resident R38's care plan dated 4/26/24, indicated the resident had a potential for pressure ulcer development related to immobility. Interventions included to inform the resident/family/caregivers of any new area of skin breakdown and do not massage over bony prominences and use milder cleansers for peri-care/washing. Review of Resident R38's Wound Assessment report dated 2/7/24, indicated the resident developed a facility acquired right heel Stage 2 pressure ulcer that measured 1.3 cm x 2.0 cm x 0.1 cm. Review of Resident R38's Wound Assessment report dated 3/29/24, indicated the resident's right heel Stage 2 pressure ulcer measured 0.8 cm x 2.0 cm x 0.1 cm. Review of Resident R38's Skin & Wound Evaluation V7.0 dated 4/4/24, completed by Wound Care Nurse Employee E4 indicated the resident's right heel pressure ulcer was now a Stage 3 and measured 4.6 cm x 3.9 cm. Education was documented as, educated resident on keeping bunny boots on and heels off of bed. Wound Care Nurse Employee E4 failed to document the depth of the resident's right heel pressure ulcer. Review of Resident R38's care plan on 7/9/24, at 10:00 a.m. failed to include Resident R38's right heel pressure ulcer and interventions for heel protector boots. During an interview on 7/10/24, at 11:39 a.m. Wound Care Nurse Employee E4 stated, I don't touch the care plans, I don't know anything about them. During an interview on 7/10/24, at 2:44 p.m. Registered Nurse Assessment Coordinator (RNAC) Employee E7 confirmed Resident R38 did not have a care plan for her right heel pressure ulcer or heel protector boots. Review of Resident R38's active physician orders on 7/10/24, at 10:00 a.m. failed to include an order for heel protector boots. During an interview on 7/10/24, at 2:35 p.m. the Director of Nursing (DON) confirmed Resident R38 did not have a physician order for heel protector boots. Review of a physician order dated 4/11/24, indicated to cleanse right heel with Vashe wound cleanser, apply Medihoney (a wound gel) over wound base, cover with alginate (an absorbent dressing) and foam every day shift. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident R38's Treatment Administration Record (TAR) for May 2024, revealed the treatment was not documented as completed on 5/1/24, 5/2/24, 5/3/24, 5/4/24, 5/5/24, and 5/8/24. Review of a physician order dated 5/9/24, indicated to cleanse right heel with Vashe wound cleaner, apply Medihoney over wound base, cover with foam every day shift. Review of Resident R38's TAR for May 2024 revealed the treatment was not documented as completed on 5/9/24, 5/14/24, 5/15/24, 5/17/24, 5/19/24, 5/24/24, and 5/29/24. During an interview on 7/10/24, at 11:05 a.m. the Director of Nursing (DON) confirmed the treatment was not documented as completed on the dates listed above. Review of Resident R38's clinical record failed to include a weekly wound assessment and measurements for the resident's right heel the week of 5/19/24. Review of a Skin/Wound note dated 6/14/24, completed by Wound Care Nurse Employee E4 stated, This RN in to assess residents wound to right heel. Wound is closed, small scab covering area measuring 0.4 cm x 0.2 cm. Received new order to apply skin prep (a treatment used to form a barrier between the skin to help preserve skin integrity) daily until scab resolves. Review of a physician order dated 6/12/24, indicated to apply skin prep to right heel every day and evening shift. Review of Resident R38's TAR for June 2024 revealed the treatment was not documented as completed on 6/15/24 during the day shift, 6/15/24 during the day shift, 6/17/24 during the day shift, 6/18/24 during the evening shift, and 6/19/24 during the day shift. During an interview on 7/10/24, at 11:05 a.m. the DON confirmed the treatment was not documented as completed on the dates listed above. Review of a Skin/Wound note dated 6/20/24, completed by Wound Care Nurse Employee E4 stated, This RN to see resident right heel, area shows worsening. Original area healing 0.2 cm x 0.2 cm, also has new area beside it that also measures 0.2 cm x 0.2 cm skin between wounds and below is macerated, resident has no complain of pain, treatments ongoing, with assess more frequently. Wound Care Nurse Employee E4 failed to document the depth and stage of the resident's right heel pressure ulcer. The wound worsened and developed a second open area. Review of a Skin/Wound note dated 6/27/24, completed by Wound Care Nurse Employee E4 stated, This RN in to see resident right heel, area healing 0.2 cm x 0.2 cm, are beside it that also measures 0.2 cm x 0.2 cm skin between wounds and below had been macerated but shows improvement. No complain of pain, no signs/symptoms of infection. Treatment of medical grade honey ongoing. Wound Care Nurse Employee E4 failed to document the depth and stage of the resident's right heel pressure ulcer. Review of a Skin/Wound note dated 7/5/24, completed by Wound Care Nurse Employee E4 stated, This RN in to assess residents right heel wound. Area surrounding wounds show improvement. 2 small wounds persist. Measuring 0.5 cm x 0.3 cm and 0.2 cm x 0.3 cm. No signs/symptoms of infection and no complain pain. Treatments ongoing. Wound Care Nurse Employee E4 failed to document the depth and stage of the resident's right heel pressure ulcer. (continued on next page)

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	395790	A. Building B. Wing	07/12/2024

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 7/10/24, at 11:30 a.m. Wound Care Nurse Employee E4 stated, I don't document depth and staging never changes, if it's a Stage 3, it stays a Stage 3 and doesn't become a Stage 2. (Resident R38) is a tough one because her pressure ulcer gets better, then worsens, then gets better, then worsens. During an interview on 7/12/24, at 1:21 p.m. Nurse Aide (NA) Employee E29 indicated the nurses would inform the nurse aides if a resident was at risk for developing a pressure ulcer. NA Employee E29 stated the nurse aides look in the resident charts while they are documenting to see if the residents are ordered preventative measures, such as protective heel boots and a schedule for turning and repositioning. NA Employee E29 stated if she knew a resident was ordered protective heel boots and they were not applied, she would apply the boots and notify the nurse. During an interview on 7/12/24, at 1:23 p.m. NA Employee E30 indicated the nurses notify the nurse aides if a resident is at risk for developing a pressure ulcer. NA Employee E30 stated the preventative measures displays in the resident charts in the task section for the nurse aides to document. NA Employee E30 stated if she knew a resident was ordered protective heel boots and they were not applied, she would go to the wound nurse and ask if they are supposed to be there, and if so, where are they? Review of the clinical record revealed that Resident R243 was admitted to the facility on [DATE]. Review of Resident 243's MDS dated [DATE], indicated diagnoses of fractured acetabulum (socket of hip bone), fractured fibula (calf bone), and fractured talus (large bone in ankle). Section GG0170 A indicated that Resident R243 required partial/moderate assistance (helper lifts or holds trunk or limbs and provides less than half the effort) to be able to roll left to right. Review of clinical record indicated that Resident R243 had intact skin at time of admission per 6/26/24, Total Body Skin Assessment. Review of Resident R243's clinical record revealed a Skin/Wound Note dated 7/2/24, that stated This RN (Registered Nurse) in to assess residents left buttock wound. Was informed by nurse aide resident had wound. Wound presents as unstageable (an ulcer that has full thickness tissue loss but is either covered by extensive nonviable tissue or a scab) to left buttocks. Covered with yellow slough, (a specific type of nonviable tissue that presents as a yellowish, moist, stringy substance) measures 1 cm (centimeter length) by 0.5 cm, (width), depth unknown. Review of Resident R243's clinical record revealed that a care plan for wound care and prevention was not implemented until 7/2/24. During an interview on 7/10/24 at 11:15 a.m. Wound Nurse Registered Nurse Employee E4 stated that she did not order any preventative wound care measures for Resident R243, and that Wound Care Registered Nurse Employee E4 does not develop any preventative wound care plans for new admissions. Wound Care Registered Nurse Employee E4 stated that when a new admission comes into the facility, she looks over their orders and admission paperwork to determine if someone is at risk. She also explained that each nursing floor has a binder where the other nurses can document any skin concerns with the residents, and that Wound Care Registered Nurse Employee E4 rounds each day to review binders for any concerns. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the binder where nurses document any skin concerns did not include any information for Resident R243. During an interview on 7/12/24, at 2:31 p.m. Unit Manager Employee E12 confirmed that the facility failed to implement a pressure injury prevention care plan for Resident R243 that resulted in an unstable pressure injury. During an interview on 7/10/24, at 8:57 a.m. the DON stated Wound Care Registered Nurse, Employee E4 completes the resident's dressing changes dressing throughout week. During an interview on 7/10/24, at 9:02 a.m. Wound Care Registered Nurse, Employee E4 stated she completes weekly skin assessments once a week. During an observation of Resident R9's left heel dressing change on 7/10/24, at 9:32 a.m. Wound Care Registered Nurse, Employee E4 failed to complete Resident R9's dressing as ordered. Wound Care Registered Nurse, Employee E4 failed to cleanse the wound with vashe cleaning solution prior to applying the resident's wound paste and completing the resident's wound dressing. Wound Care Registered Nurse, Employee E4 indicated Resident R9's left heel pressure ulcer measured 1.5 centimeters (cm) x 0.5 cm x 0.2 cm. Wound Care Registered Nurse, Employee E4 stated it's a stage two, part of it was unstageable, it was confusing, now stage 2. During an interview on 7/10/24, at 10:56 a.m. the DON confirmed the facility failed to prevent an avoidable pressure ulcer development that resulted in the actual harm of a new pressure ulcer, complete a Braden Assessment after the resident was identified as a pressure ulcer risk, obtain an order for bunny boots, initiate a care plan for a resident's pressure ulcer, stage pressure ulcers correctly, complete weekly skin assessments as ordered, and complete a dressing change as ordered for Resident R9. During an interview on 7/10/24, at 11:40 a.m. Wound Care Registered Nurse, Employee E4 stated a stage three pressure ulcer you would see bone and tendon and a stage 2 pressure ulcer is an opening of the skin to the tissue or muscle, that doesn't reach the bone. Review of the clinical record revealed that Resident R285 was admitted to the facility on [DATE], with diagnoses of stage 3 pressure ulcer, anxiety, and dementia. Review of Resident R285's progress note dated 6/21/24, at 8:28 p.m. indicated the resident arrived by ambulance to the facility. It was indicated the resident had a stage 3 on the coccyx. No documentation of wound measurements or description was documented. Review of Resident R285's clinical record from 6/21/24, to 6/22/24, failed to include a physician order for Resident R285's stage 3 coccyx pressure ulcer. Review of Resident R285's physician order dated 6/23/24, indicated to cleanse open area to coccyx with soap and water, apply foam dressing every evening shift. Review of Resident 285's MDS dated [DATE], Section M- Skin Conditions failed to indicate the resident was receiving skin and ulcer treatments such as pressure ulcer care, turning and repositioning program, and pressure reducing device for chair. (continued on next page)

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	07/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident R285's care plan dated 6/28/24, indicated the resident is at risk for skin integrity. Interventions included to consult wound care nurse as appropriate, evaluate skin integrity, position resident to reduce causes of friction or shear, provide skin care per facility guidelines and as needed, utilize pillow or foam wedges to avoid direct contact with bony prominences, and utilize pressure relieving devices on appropriate surfaces. It was indicated to provide wound management and interventions indicated to measure ulcer on regular intervals, monitor ulcer for signs of progression or declination, provide wound care per treatment order, and notify provider if no signs of improvement on current wound regimen. The facility failed to include the location and stage of Resident 285's pressure ulcer. Review of Resident R285's June 2024 Treatment Administration Record revealed the resident's coccyx dressing change was not signed off for completion for three of eight days. The resident's dressing change was left blank and not signed off for completion on 6/25/24, 6/28/24, and 6/29/24. Review of Resident R285's clinical record from 6/21/24, through 6/30/24, failed to include documentation of Resident R285's Stage 3 coccyx pressure ulcer. The facility failed to monitor Resident R285's pressure ulcer. Review of Resident R285's progress note dated 7/1/24, entered by Wound Care Registered Nurse, Employee E4 at 1:24 p.m. indicated this RN was called to the resident's room by a nurse aide. Resident had wound measuring 4 cm x 3 cm x 0.7 cm. The wound bed was pink/red with 20% yellow slough. It was indicated a new order for Santyl (type of medication that helps remove dead skin tissue and aid in healing) and a foam dressing was ordered. The resident is now safe in bed and spends time in both chair and bed to redistribute pressure. During an interview on 7/10/24, at 11:30 a.m. Wound Care Registered Nurse, Employee E4 confirmed the facility failed to assess Resident R285's stage 3 coccyx pressure ulcer upon admission. Wound Care Registered Nurse, Employee E4 stated she was first made aware of Resident R285's coccyx wound on 7/1/24, when the Registered Nurse Assessment Coordinator told her he came in with it. It was indicated upon admission Wound Care Registered Nurse, Employee E4 will look at referral, discharge instructions, or rely on the floor nurse's official assessment to see if they found any skin concerns. If they find something, the wound care nurse is notified via the Skin Concern binder that is located on each floor. Wound Care RN, Employee E4 stated she rounds every day on the binder, and she also has protocols in there if they find one so they know what they can order. Review of the facility's Skin Concerns list for the month of June 2024 and July 2024 failed to include Resident R285's stage 3 coccyx wound. Review of Resident R285's clinical record on 7/10/24, at 11:28 a.m. failed to include documentation of the resident's coccyx wound, a total of 9 days since the last wound assessment. The facility failed to monitor Resident R285's wound. Review of Resident R285's physician orders on 7/10/24, at 11:31 a.m. failed to include any interventions related to the resident's pressure ulcer risk. (continued on next page)

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	395790	A. Building B. Wing	07/12/2024

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 7/12/24, at 1:30 p.m. Registered Nurse, Employee E15 indicated if a resident is always in bed, always refuse to sit in chair, not changed, always wet, then they are identified as a pressure ulcer risk. RN, Employee E15 stated Braden Assessments are completed upon admission, and skin checks are completed weekly. RN, Employee E15 indicated pressure ulcers develop over bony prominences, especially those who are very skinny, in the coccyx area sacrum, heels. Interventions to prevent skin breakdown included skin prep every shift for those at risk. Bunny boots are used for some of the residents, and the physician order will be entered in the resident's clinical record. If it is discovered a resident does not have an order for pressure ulcer interventions such as bunny boots, then the doctor will be notified and an order is obtained. Pressure ulcer interventions must be entered in the resident's care plan. RN, Employee E15 indicated if there is a concern for wounds, the wound care nurse is notified in the skin concerns binder located at the nursing station. During an interview on 7/12/24, at 1:36 p.m. Registered Nurse, Employee E24 stated a resident's pressure ulcer risk depends on their level of mobility, if they had recent surgery, or if they are malnourished. It was indicated interventions such as turning and repositioning are entered and pushed over to the care plan for nurse aides to document. RN, Employee E24 indicated dietary will look at weights, and add supplements if needed. It was indicated other pressure ulcer interventions include obtaining an air mattress, cushions for chairs, and barrier cream. It was indicated staff are required to document in the pressure ulcer interventions that were implemented in the resident's clinical record. RN, Employee E24 stated the wound care nurse evaluates all newly identified wounds and follows up within 24 hours. The wound care nurse is responsible for staging the wounds. 28 Pa. Code:211.10(a)(c)(d) Resident care policies. 28 Pa. Code: 211.12(d)(1)(2)(3)(5) Nursing services.

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	395790	A. Building B. Wing	07/12/2024

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46167 Based on review facility polices, observations, clinical records, and staff interviews it was determined that the facility failed to make certain that appropriate treatments and services were provided for the use of a urinary catheter as required for three of four residents (Resident R53, R93, and R129). Findings include: Review of facility policy Catheter Care, Urinary dated 5/18/24, indicated that the facility should ensure that the catheter tubing and drainage bag are kept off the floor. Review of facility policy Resident Rights dated 5/18/24, indicated that residents have the right to a dignified existence. Review of facility policy Dignity dated 5/18/24, indicated that each resident shall be cared for in a manner that promotes and enhances his or her sense of well- being, level of satisfaction with life, and feelings of self-worth and self-esteem. Residents are treated with dignity and respect at all times. Demeaning practices and standards of care that compromise dignity is prohibited. Staff are expected to promote dignity and assist residents, for example: Helping the resident to keep urinary catheter bags covered. Review of Resident R53's clinical record indicated the resident was admitted to the facility on [DATE]. Review of Resident R53's MDS (Minimum Data Set, periodic assessment of resident care needs) dated 6/16/24, indicated diagnoses of spina bifida (a birth defect in which a spinal cord fails to develop properly), hypertension (high blood pressure in the arteries), and depression. Section H-Bladder and Bowel indicated the utilization of an urostomy (a surgical procedure that creates a stoma for the urinary system). Review of the clinical record revealed that Resident R53 had a physician's order dated 3/8/24, for urostomy care. During an observation on 7/8/24, at 10:30 a.m. Resident R53 was observed lying in bed with his urinary catheter bag laying on the floor without a dignity bag. During an interview on 7/8/24, at 10:35 a.m. Licensed Practical Nurse Employee E14 stated, No, he doesn't have one. I'll take care of that now. During an interview on 7/8/24, at 10:19 a.m. Licensed Practical Nurse Employee E14 confirmed that Resident R53 urinary bag was laying on the floor without a dignity bag. Review of clinical record revealed that Resident R93 was admitted to the facility on [DATE]. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 93's MDS (Minimum Data Set, periodic assessment of resident care needs) dated 5/11/24, indicated diagnoses of high blood pressure, chronic kidney disease, and hyponatremia (low sodium level in the blood). Section H-Bladder and Bowel indicated the utilization of an indwelling catheter. Review of the clinical record revealed that Resident R93 had a physician's order dated 2/18/24, for an indwelling urinary catheter. Review of the above physician's order did not include a diagnosis for the urinary catheter as required. During an interview on 7/12/24, at 8:52 a.m. Director of Nursing confirmed that the facility failed to include a diagnosis for the urinary catheter as required. Review of the clinical record revealed that Resident R129 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 129's MDS dated [DATE], indicated diagnoses of high blood pressure, muscle wasting, and dysphagia (difficulty swallowing). Section H-Bladder and Bowel indicated the utilization of an indwelling catheter. Review of clinical record revealed that Resident R129 had a physician's order dated 6/17/24, for an indwelling urinary catheter. During an observation on 7/8/24, at 11:25 a.m. urinary drainage bag was hanging from Resident R129's bed frame with no dignity bag. During an interview on 7/8/24, at 1:19 p.m. Licensed Practical Nurse Employee E10 confirmed that the facility failed to make certain that appropriate treatments and services were provided for Resident R129's catheter. During an interview on 7/8/24, at 3:15 p.m. the Director of Nursing confirmed that the facility failed to make certain that appropriate treatments and services were provided for the use of a urinary catheter as required for three of four residents (Resident R53, R93, and R129). 28 Pa Code: 201.14 (a) Responsibility of licensee. 28 Pa code: 211.10 (c)(d) Resident care policies. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46167 Based on facility policy, medical record review, observations, and staff interviews, it was determined that the facility failed to provide necessary services and properly monitor and assess weight and nutrition status for five of seven residents reviewed (Resident R28, R83,R91, R129, and R243). Findings include: Review of facility policy Weight Assessment and Intervention dated 5/18/24, indicated that residents are to weighed upon admission and at intervals established by the interdisciplinary team. Any weight change of 5% or more since the last weight assessment is retaken the next day for confirmation. If the weight is verified nursing will immediately notify the dietitian in writing. Unless notified of significant weight change, the dietitian will review the unit weight record monthly to follow individual weight trends over time. The threshold for significant unplanned and undesired weight loss will be based on the following criteria: a) 1 month: 5% weight loss is significant; greater than 5% is severe. b) 3 months: 7.5% weight loss is significant; greater than 7.5% is severe. c) 6 months: 10% weight loss is significant greater than 10% is severe. If the weight change is desirable, this is documented. Undesirable weight change is evaluated by the treatment team whether or not the criteria for significant weight change has been met. Review of the clinical record indicated Resident R28 was admitted to the facility on [DATE]. Review of Resident R28's Minimum Data Set (MDS - a periodic assessment of care needs) dated 5/8/24, indicated diagnoses of high blood pressure, hemiplegia (paralysis on one side of the body), and dementia (a group of symptoms that affects memory, thinking and interferes with daily life). Review of clinical record revealed that Resident R28's weight history was as follows: 12/1/23 150.1 pounds 1/6/24 141.6 pounds (5.66% loss in one month) 2/4/24 142.8 pounds 3/8/24 138.8 pounds 4/12/24 138.8 pounds 4/18/24 126.5 pounds (8.86% loss in 6 days) 4/25/24 138.8 pounds (continued on next page)

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	395790	A. Building B. Wing	07/12/2024

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5/9/24 138.8 pounds 5/21/24 122.0 pounds (12.10% loss in 12 days) 6/3/24 116.0 pounds (11.94% loss in one month, 22.72% loss in six months) Review of Resident R28's clinical record revealed a current physician order dated 2/6/24, indicated staff to feed family request. Review of Resident R28's clinical record revealed a current physician order dated 2/14/24, indicated the resident is to have a regular diet, easy-to-chew texture, section plate, staff to feed, and a diabetic snack. Review of Resident R28's care plan dated 4/22/24, indicated the resident requires set up assistance with eating. The care plan failed to indicate the resident is a staff feed. Resident R28's care plan was updated on 5/24/24, and indicated the resident had unplanned/unexpected weight loss due to poor food intake and poor prognosis as evidence by 16.4% weight loss in three months. Interventions indicated to monitor and evaluate any weight loss, determine percentage lost and follow facility protocol for weight loss. It was indicated if weight decline persists, contact physician and dietician immediately. Review of Resident R28's progress note dated 7/1/24, at 10:26 a.m. entered by Registered Nurse, Employee E4 indicated team met to discuss residents weight loss. Over a 6 month period resident has lost weight but has since stabilized, ensure was provided but refused by resident, resident is a staff feed but refuses at times. Will continue to monitor. During an observation on 7/8/24, at 12:54 p.m. the third lunch cart (Cart 7) arrived to the second floor and staff began passing lunch trays. During an observation on 7/8/24, at 1:00 p.m. Nurse Aide, Employee E31 dropped off Resident R28's lunch tray and stated I will be back to feed you, I'll be right back. During an observation on 7/8/24, at 1:04 p.m. Resident R28's lunch tray was no longer on the resident's bedside table. During an observation on 7/8/24, at 1:16 p.m. Resident R28's lunch tray was observed in Cart 7 with the lid cover not completely on. The resident's lunch was untouched. During an interview on 7/8/24, at 1:31 p.m. Nurse Aide, Employee E25 stated each floor has a list of resident who need fed. NA, Employee E25 stated we try to get residents who need fed in the dining room, however today is a little different, a lot of agency, not a realistic day today. Review of the facility provided feeding list on 7/8/24, at 1:40 p.m. indicated Nurse Aide, Employee E31 was assigned to feed Resident R28 on 7/8/24, for lunch. During an observation on 7/8/24, at 1:41 p.m. staff were observed picking up trays from resident's rooms on the [NAME] Hall. (continued on next page)

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	395790	A. Building B. Wing	07/12/2024

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 7/8/24, at 1:43 p.m. Cart 7 still contained Resident R28's lunch tray uncovered with other resident's finished trays on it. A staff member was observed taking the cart to the elevator to be picked up. During an interview and observation on 7/8/24, at 1:45 p.m. Nurse Aide, Employee E31 was observed sitting in another resident's room, not actively feeding the resident. NA, Employee E31 confirmed she did not feed Resident R28. Review of Resident R28's clinical record on 7/8/24, at 1:50 p.m. from 7/1/24, to 7/8/24, failed to indicate the resident was fed for all meals each shift. During an interview on 7/8/24, at 1:52 p.m. the Director of Nursing confirmed the facility failed to provide necessary services and feed Resident R28 as ordered. Review of Resident R28's clinical record on 7/10/24, at 10:30 a.m. failed to include an updated monthly weight for July. During an interview on 7/10/24, at 12:55 p.m. Assistant Director of Nursing (ADON) Employee E4 indicated residents are weighed monthly, and if significant weight loss is identified they should be reweighed. Review of the clinical record revealed that Resident R83 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident R83's MDS dated [DATE], indicated diagnoses of high blood pressure, dementia (a group of symptoms that affects memory, thinking and interferes with daily life), and hypernatremia (high sodium levels in the blood often due to water loss). Section K0710 A indicated that proportion of total calories the resident received through tube feeding (nutrition provided via a tube that is inserted into the stomach when inadequate nutrition is able to be obtained through eating) was 26-50% of total caloric intake for the past seven days. Review of clinical record revealed that Resident R83's weight history was as follows: 10/6/23 133.4 pounds 11/2/23 132.2 pounds 12/8/23 134.0 pounds 1/5/24 136.2 pounds 2/26/24 135.4 pounds 3/8/24 133.6 pounds 4/8/24 119.0 pounds (11% loss in one month, 12.6% loss in three months, and 10.8% loss in six months) (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4/10/24 119.0 pounds (same weight loss indicators as above) 4/24/24 118.5 pounds (11.3% loss in one month, 13% loss in three months, and 11.2% in six months) Review of Resident R83's clinical record revealed a physician's order dated 2/21/24, for an oral diet of easy to chew, and an order dated 3/31/24, for Liquacel (a liquid protein) two times per day by mouth. Review of Resident R83's clinical record revealed a physician's order dated 3/20/24, to provide Jevity 1.2 (a tube feeding formula to provide liquid nutrition via a feeding tube) at 60 milliliters (ml) per hour for 12 hours per day, as well as an order for 100 ml of water flush every four hours during tube feedings. This provides 864 calories per day and 881 ml of water. Review of the clinical record revealed a physician's order dated 3/30/24, to flush tube feeding with 100 ml of water every 4 hours during feeds (same as above). During an interview on 6/8/24, at 8:40 a.m. Director of Nursing informed that the facility switched over to a new electronic charting system on 4/1/24, when new owners took over the facility. Review of clinical record revealed that Resident R83 did not have an order for tube feeding on 4/1/24, and 4/2/24. Review of clinical record revealed that Resident R83's had a physician's order for Jevity 1.2 @ 60 ml per hour for 12 hours written on 4/3/24. This along with the water flush order written on 3/30/24, provided 864 calories and 881 ml of water. After weights were obtained on 4/8/24, and 4/10/24, at 119.0 pounds with a significant weight loss as stated above, clinical record review revealed a note in Nutrition Progress notes dated 4/12/24, that stated the following: Diabetisource AC (a tube feeding formula to provide liquid nutrition via a feeding tube) at 60 ml per hour (8pm up and 4 am down) with water flush 50 ml every three hours starting 4/12/24. Review of the above documentation revealed that this new change provided 576 calories per day and 541 ml of water day, which is reduction of 288 calories and 340 ml of water from the previous order. Documentation did not reveal an explanation for the tube feed change or why calories and fluid were reduced. Review of 4/12/24 Nutrition Progress notes did not reveal any indication that Resident R83's weights obtained on 4/8/24, and 4/10/24 had been reviewed for significant weight loss. Review of Resident R83's clinical record revealed that the physician's order for Jevity 1.2 tube feeding formula written on 4/3/24, and the water flush order written on 3/30/24 were discontinued on 4/12/24. Review of clinical record revealed Resident R83 had lab work completed on 4/16/24, that included a sodium level result of 156 mmol/L (millimoles per liter- a measure of the amount of a substance), which is considered to be a high value and is hypernatremia. (continued on next page)

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	395790	A. Building B. Wing	07/12/2024

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of clinical record revealed that Resident R83 was sent to the hospital on 4/16/24, and returned on 4/20/24. Review of clinical record revealed that Resident R83 had a Nutrition Assessment completed on 4/22/24, that stated that weight was 119 pounds and that Resident R83 had an unplanned weight loss of 10.9% in one month, and that resident was receiving an easy to chew diet, Diabetisource AC at 60 ml per hour for eight hours per day, Liquacel twice per day (by mouth) and Glucerna (a nutrition supplement) twice per day (by mouth). Review of clinical record revealed Resident R83 had a Nutrition Progress note completed on 4/24/24, that stated the following: April weight is 119 pounds. Resident triggered for a 10.9% weight loss in one month and 10.8% decrease in 6 months. Current diet is regular easy to chew consistency. Resident refuses meal trays and supplement. Recently she starts to accept fluid. Resident is also on tube feeding which only provides 42. 6% of daily needs. Weight loss is due to poor oral meal and supplement intake. Speech therapist is monitoring safety intake of meals. Will continue to encourage intake and monitor intake. Review of the above note concluded that current intake is not adequate, weight loss had occurred, and tube feeding did not meet estimated caloric needs, but did not include any strategy to increase the calories, or increase the tube feeding to meet Resident R83's nutrition needs. During an interview on 7/12/24 at 2:20 p.m. Registered Dietitian (RD) Employee E11 confirmed that the facility failed to provide an order for tube feeding on 4/1/23, and 4/2/24, and failed to appropriately address Resident R83's weight loss that occurred on 4/8/24, and that a change in tube feeding order on 4/12/24 was a reduction of calories and water for Resident R83. Review of the clinical record revealed that Resident R91 was admitted to the facility on [DATE]. Review of Resident 91's MDS dated [DATE], indicated diagnoses of high blood pressure, repeated falls, and underweight. Review of Nutrition Assessment completed on 6/26/24, indicated that weight of 116 pounds was used to complete the nutritional evaluation and that this weight of 116 pounds was obtained from the hospital records and indicated that Resident R91 had a BMI (body mass index - a tool used to screen for weight categories) of 21 which indicated that Resident R91 had a BMI which is considered to be normal. This Nutrition Assessment stated that the plan of care was to continue with a regular diet/thin liquids, to maintain current level of function. Will continue to monitor PRN (as needed). Review of clinical record revealed that resident was not weighed at the facility until 7/8/24, when her weight was recorded at 107.4 pounds, which indicated a BMI of 19.6 which also considered to be normal, and an additional weight was obtained on 7/10/24, of 100.2 pounds which indicated a BMI of 18.3 which is considered to be underweight. During an interview on 7/10/24, at 12:47 p.m. RD Employee E11 confirmed that the facility failed to weigh Resident R91 upon admission, and that use of a hospital weight could be inaccurate, therefore, failed to accurately assess Resident R91's nutrition and weight status. (continued on next page)

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	07/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Seneca Place	5360 Saltsburg Road Verona, PA 15147

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the clinical record revealed that Resident R129 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 129's MDS dated [DATE], indicated diagnoses of high blood pressure, muscle wasting, and dysphagia (difficulty swallowing). Review of Resident R129's clinical record revealed that weight upon 6/5/24 admission was 120.0 pounds. Review of clinical record revealed that Resident R129 was transferred to the hospital on 6/11/24, and returned on 6/16/24. Review of clinical record revealed that Resident R129 had Nutrition Assessment completed on 6/17/24, at 2:06 p.m. that stated Re-admission weight has not been obtained yet. Requested weight from nursing. Using hospital weight of 116.6 pounds to estimate weight. Height was recorded at 60 inches and BMI was reported to be within normal limits. Ensure Plus (an oral nutritional formula) was added twice per day. Review of clinical record revealed that weight was obtained on 6/17/24, at 8:35 p.m. at 111.0 pounds, which reflects a significant loss of 7.5% in less than one month. Review of clinical record revealed a care plan dated 6/17/24, that stated resident has potential nutritional problem (calorie/protein malnutrition) related to inadequate oral intake and that the goal is Resident will comply with recommended diet for weight reduction daily through review date. Review of clinical record revealed that Resident R129 had a Nutrition progress note recorded on 6/24/24, that indicated that diet was changed to pureed texture, but that intake remains poor. Current weight is 111 pounds. Review of 6/24/24 Nutrition progress note failed to identify that weight of 111 pounds indicated that Resident R129 had a significant weight loss of 7.5% in less than one month. During an interview on 7/10/24, at 12:37 p.m. RD Employee E11 confirmed that the facility failed to identify a significant weight loss for Resident R129, and that a goal for continued weight loss was not appropriate. Review of the clinical record revealed that Resident R243 was admitted to the facility on [DATE]. Review of Resident 243's MDS dated [DATE], indicated diagnoses of fractured acetabulum (socket of hip bone), fractured fibula (calf bone), and fractured talus (large bone in ankle). Review of clinical record revealed a Nutritional Assessment for Resident R243 dated 6/27/24, that included a weight of 198 pounds. Review of clinical record revealed recorded weighs for Resident R243 were 166.1 pounds on 7/5/24, and 166.1 pounds on 7/8/24. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 7/10/24 at 12:52 p.m. RD Employee E11 confirmed that Resident R243 was not weighed upon admission, and that the weight used in Nutritional assessment dated [DATE], of 198 pounds was not accurate. 28 Pa. Code: 201.18(b)(1)(e)(1) Management. 28 Pa. Code: 211.12(d)(1)(3)(5) Nursing services.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46167 Based on clinical record review, observations, and staff interview, it was determined the facility failed to provide to provide appropriate care and services to residents receiving tube feedings for two of two residents reviewed (Residents R51 and R83). Finding include: Review of facility policy Enteral Nutrition (nutrition provided via a tube inserted into the stomach) dated 5/18/24, indicated adequate nutritional support through enteral nutrition is provided to residents as ordered. The nurse confirms that orders for enteral nutrition are complete. Complete orders include the enteral nutrition product, and instructions for flushing. Review of the clinical record revealed that Resident R51 was admitted to the facility on [DATE], with diagnoses of high blood pressure, anxiety, depression, and stroke (occurs when the blood supply to part of the brain is blocked or reduced. This prevents brain tissue from getting oxygen and nutrients.) Review of Resident R51's care plan dated 5/3/24, indicated the resident requires a tube feeding due to dysphagia (difficulty swallowing). It was indicated the resident is dependent with tube feeding and water flushes. See physician orders for current feeding orders. Review of Resident R51's physician order dated 6/3/24, indicated the resident is to have 95 cc tube feeding flush every four hours, six times a day. Review of Resident R51's MDS dated [DATE], indicated the diagnoses were current. Section K: Nutritional Approaches indicated the resident received a feeding tube while a resident. Review of Resident R51's physician order dated 6/14/24, indicated to administer Glucerna 1.2 (a high calorie/high protein specialized liquid medical food) at 60ml/hr, three times a day, continuously. During an observation on 7/8/24, 10:14 a.m. Resident R51's water flush bag was observed empty. During an interview on 7/8/24, at 10:26 a.m. Licensed Practical Nurse, Employee E14 confirmed the facility failed to administer Resident R51's water flush as ordered. Review of the clinical record revealed that Resident R83 was admitted to the facility on [DATE], and readmitted on [DATE]. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident R83's MDS dated [DATE], indicated diagnoses of high blood pressure, dementia (a group of symptoms that affects memory, thinking and interferes with daily life), and hypernatremia (high sodium levels in the blood often due to water loss). Section K0710 A indicated that proportion of total calories the resident received through tube feeding (nutrition provided via a tube that is inserted into the stomach when inadequate nutrition is able to be obtained through eating) was 26-50% of total caloric intake for the past seven days Review of Resident R83's clinical record revealed a physician's order written on 4/12/24, under the category Enteral Feed that stated 60 ml per hour 8pm up 4am down total 8 hours, as well as an order for tube feeding flushes with 50 ml water every three hours (during feeds). Review of the above order did not include the name of the formula to be used. During an interview on 7/12/24 at 2:20 p.m. Registered Dietitian (RD) Employee E11 confirmed that the facility failed to identify the type of tube feeding to be used in 4/12/24 enteral feeding order. 28 Pa. Code: 201.18(b)(1) Management. 28 Pa. Code: 211.12(d)(1) Nursing services.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46337 Based on review of facility policy, observations, interviews, and clinical record review, it was determined that the facility failed to provide appropriate respiratory care for three of three residents (Residents R68, R285, and R334). Findings include: Review of facility policy Oxygen Administration dated 5/18/24, indicated prior to administering oxygen verify there is a physician's order and review the resident's care plan to assess for any special needs of the resident. It was indicated to check the mask, tank, and humidifying jar to be sure they are in good working order. Be sure there is water in the humidifying jar and the water level is high enough that the water bubbles as oxygen flows through. Review of the clinical record indicated Resident R68 was admitted to the facility on [DATE]. Review of Resident R68's Minimum Data Set (MDS - a periodic assessment of care needs) dated 6/2/24, indicated diagnoses of high blood pressure, asthma (a condition where the airways narrow and swell), and Post-Traumatic Stress Disorder (PTSD - a disorder in which a person has difficulty recovering after experiencing or witnessing a terrifying event and may have triggers that can bring back memories of trauma accompanied by intense emotional and physical reactions). Review of Resident R68's care plan dated 5/15/24, indicated the resident has oxygen therapy related to respiratory illness and the resident will have no signs or symptoms of poor oxygen absorption through the review date. During an observation on 7/8/24, at 10:34 a.m. Resident R68's nasal cannula tubing was dated 6/29 and the humidification bottle (a medical device used to enhance moisture and reduce dryness of supplemental oxygen) did not have a date. During an interview on 7/8/24, at 10:42 a.m. Licensed Practical Nurse (LPN) Employee E1 confirmed there was no date on Resident R38's humidification bottle. Review of Resident R68's active physician orders on 7/10/24, failed to reveal an order for oxygen therapy. During an interview on 7/10/24, at 12:22 p.m. the Director of Nursing (DON) confirmed that Resident R68 did not have a physician order for oxygen therapy. Review of the clinical record indicated that Resident R285 was admitted to the facility on [DATE]. Review of Residents R285's MDS dated [DATE], indicated the diagnoses of respiratory failure (not enough oxygen in the blood), heart failure (a progressive heart disease that affects pumping action of the heart muscles, which causes fatigue and shortness of breath.), and hypostatic pneumonia (pneumonia (infection of the air sacs in one or both lungs) that usually results from the collection of fluid in the lungs and occurs especially in those lying supine (face upward) for extended periods.) (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident R285's care plan dated 6/28/24, indicated the resident has impaired gas exchange and to administer oxygen as per prescribed or per standing order. Resident R285 failed to have a care plan for oxygen. During an observation on 7/8/24, at 10:22 a.m. Resident R285 was observed using 2 liter of oxygen via nasal cannula (device that gives you additional oxygen through your nose). Resident R285's humidification bottle was observed to be empty. During an interview on 7/8/24, at 10:26 a.m. LPN Employee E14 confirmed Resident R285's humidification bottle was empty. Review of Resident R285's physician orders on 7/10/24, at 11:19 a.m. failed to include an order for Resident R285's oxygen. During an interview on 7/10/24, at 12:21 p.m. the DON confirmed Resident R285 failed to have a physician order and care plan for oxygen. Review of the clinical record indicated Resident R334 was admitted to the facility on [DATE]. Review of Resident R334's MDS dated [DATE], indicated diagnoses of high blood pressure, End-Stage Renal Disease (ESRD - an inability of the kidneys to filter blood), and Chronic Obstructive Pulmonary Disease (COPD - a group of progressive lung disorders characterized by increasing breathlessness). Review of a physician order dated 7/4/24, indicated to provide oxygen at two liters per minute via a nasal cannula at bedtime. During an observation on 7/8/24, at 10:34 a.m. no date was noted on Resident R334's nasal cannula tubing or humidification bottle. During an interview on 7/8/24, at 10:42 a.m. LPN Employee E1 confirmed there was no date on Resident R334's nasal cannula tubing and humidification bottle. Review of Resident R334's current comprehensive care plan failed to indicate a plan of care by the facility for supplemental oxygen usage. During an interview on 7/10/24, at 2:35 p.m. the DON confirmed Resident R334 did not have a care plan for supplemental oxygen use. During an interview on 7/10/24, at 2:35 p.m. the DON confirmed that the facility failed to provide appropriate respiratory care for three of three residents (Residents R68, R285, and R334). 28 Pa. Code: 201.14(a) Responsibility of licensee. 28 Pa. Code: 211.10(c)(d) Resident care policies. 28 Pa. Code: 211.11 (a)(c)(d) Resident care plan. 28 Pa. Code 211.12(d)(1)(2)(3)(5) Nursing services.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46337 Based on review of resident clinical records, facility policy and staff interview it was determined the facility failed to provide consistent and complete communication with the dialysis center for two of two residents reviewed (Residents R4 and R334), and failed to implement a dialysis care plan for one of two resident's (Resident R4). Findings include: Review of the facility policy End-Stage Renal Disease (ESRD), Care of Resident with dated 5/18/24, indicated agreements between the facility and the contracted ESRD facility include all aspects of how the resident's care will be managed including how the care plan will be developed and implemented, and how information will be exchanged between facilities. Review of the clinical record indicated that Resident R4 was admitted to the facility on [DATE]. Review of Resident R4's Minimum Data Set (MDS- a periodic assessment of care needs) dated 5/8/24, indicated with the diagnoses of end stage kidney disease (a condition where the kidney reaches advanced state of loss of function), dependence on dialysis (a blood purifying treatment given when kidney function is not optimum), and high blood pressure. Review of R4's physician order dated 3/20/24, indicated the resident has dialysis one time a day every Monday, Wednesday, and Friday. Review of Resident R4's care plan dated 5/13/24, failed to include a care plan for the resident's dialysis. Review of Resident R4's Dialysis Treatment Record communication forms for the Month of June and July revealed eight forms were incomplete on 6/12/24, 6/17/24, 6/28/24, and 7/1/24, and four forms failed to include a date. During an interview on 7/9/24, at 1:11 p.m. Licensed Practical Nurse (LPN), Employee E16 indicated each resident that receives dialysis has a binder for dialysis communication that is kept at the nurses station. LPN, Employee E16 stated that the resident's take the binder to dialysis, we fill in above and they fill in below. During an interview on 7/9/24, at 1:15 p.m. LPN, Employee E16 confirmed Resident R4 did not have a care plan for care plan for dialysis. During an interview on 7/9/24, at 1:17 p.m. LPN, Employee E6 confirmed Resident R4's Dialysis Treatment Record communication forms were not completed for eight of 11 forms. Review of the clinical record indicated Resident R334 was admitted to the facility on [DATE]. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident R334's MDS dated [DATE], indicated diagnoses of high blood pressure, ESRD, and Chronic Obstructive Pulmonary Disease (COPD - a group of progressive lung disorders characterized by increasing breathlessness). Review of a physician order dated 7/4/24, indicated renal dialysis every Monday, Wednesday, and Friday, however failed to include which dialysis facility or a time. During an interview on 7/11/24, at 12:32 p.m. the Director of Nursing (DON) confirmed that Resident R334's dialysis order was incomplete and did not include which dialysis facility or a time. Review of Resident R334's Dialysis Treatment Record communication forms failed to reveal facility staff provided communication to the dialysis facility for 11 of 15 days on 5/17/24, 5/20/24, 5/22/24, 5/24/24, 5/27/24, 5/29/24, 6/10/24, 6/14/24, and 6/24/24, and two forms failed to include a date. During an interview on 7/9/24, at 2:47 p.m. the DON confirmed Resident R334's Dialysis Treatment Record communication forms were not completed for 11 of 15 days. 28 Pa. Code: 211.12(d)(1)(2)(3)(5) Nursing services. 28. Pa. Code: 211.10(a)(c)(d) Resident care policies. 28 Pa. Code: 201.18(b)(e)(1)(2) Management 28 Pa. Code: 201.29(a)(b)(c)(d)(j)(m) Resident rights. 28 Pa. Code: 201.14(a)(c)(d)(e) Responsibility of licensee.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48546 Based on review of facility policy, resident record review, and staff interviews, it was determined that the facility failed to provide a trauma survivor with trauma informed care to eliminate or mitigate triggers that may cause re-traumatization of the resident for two of two residents (Resident R6 and R68). Findings include: Review of facility policy Trauma-Informed and Culturally Competent Care dated 5/18/24, indicated resident assessment involves an in-depth process of evaluating the presence of symptoms, their relationship to trauma, as well as the identification of triggers. The facility will develop individualized care plans that address past trauma in collaboration with the resident and family, identify and decrease exposure to triggers that may re-traumatize the resident, and recognize the relationship between past trauma and current health conditions. Review of the clinical record indicated Resident R6 was admitted to the facility on [DATE]. Review of Resident R6's MDS (Minimum Data Set, periodic assessment of resident care needs) dated 5/6/24, indicated diagnoses of high blood pressure, diabetes (a metabolic disorder in which the body has high sugar levels for prolonged periods of time), and Post-Traumatic Stress Disorder (PTSD - a disorder in which a person has difficulty recovering after experiencing or witnessing a terrifying event and may have triggers that can bring back memories of trauma accompanied by intense emotional and physical reactions). Review of Resident R6's care plan on 4/22/24, did not include a plan of care developed with goals and interventions related to post-traumatic stress disorder. During an interview on 7/10/24, at 2:05 p.m. Social Service Director (SSD) Employee E5 stated, Resident R6 must have screened negative on our trauma-informed care screen. If they screen negative, then it doesn ' t generate me to put in a careplan but she does have a diagnoses of PTSD. During an interview on 7/10/24, at 2:13 p.m. SSD Employee E5 confirmed that the facility failed to provide a trauma survivor with trauma informed care to eliminate or mitigate triggers that may cause re-traumatization of the resident for Resident R6. Review of the clinical record indicated Resident R68 was admitted to the facility on [DATE]. Review of Resident R68's MDS dated [DATE], indicated diagnoses of high blood pressure, asthma (a condition where the airways narrow and swell), and Post-Traumatic Stress Disorder (PTSD - a disorder in which a person has difficulty recovering after experiencing or witnessing a terrifying event and may have triggers that can bring back memories of trauma accompanied by intense emotional and physical reactions). Review of Resident R68's care plan on 7/9/24, did not include a plan of care developed with goals and interventions related to post-traumatic stress disorder. (continued on next page)

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	395790	A. Building B. Wing	07/12/2024

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/10/24, at 1:52 p.m. Social Service Director (SSD) Employee E5 stated, Resident R68 screened negative on our trauma-informed care screen. If she would have answered yes, it would have triggered the care plan. It was probably just an oversite. During an interview on 7/10/24, at 1:56 p.m. SSD Employee E5 confirmed that the facility failed to provide a trauma survivor with trauma informed care to eliminate or mitigate triggers that may cause re-traumatization of the resident for Resident R68. 28 Pa. Code: 201.14(a) Responsibility of licensee. 28 Pa. Code: 201.18(b)(1) Management.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48546 Based on observations, review of facility policy, clinical record review, and staff interview, it was determined that the facility failed to maintain accurate resident care plans and conduct ongoing accurate assessments to ensure that bedrails were used to meet residents' needs and the risks associated with bedrail usage for five of five residents (Residents R2, R6, R21, R28, and R64). Findings include: Review of Title 42 Code of Federal Regulations (CFR) S483.25(n) - Bed Rails states that the facility must assess the resident for risk of entrapment from bed rails prior to installation. Additionally, there should be evidence in the resident's records that the facility performed ongoing assessments to assure that the bed rail is used to meet the resident's needs and that there is an ongoing evaluation of risks associated with bed rail usage. Review of facility policy Bed Safety and Bed Rails dated 5/18/24, indicated the use of bed rails or side rails (including temporarily raising the side rails for episodic use during care) is prohibited unless the criteria for use of bed rails have been met, including attempts to use alternatives, interdisciplinary evaluation, resident assessment, and informed consent. Review of the clinical record indicated Resident R2 was admitted to the facility on [DATE]. Review of Resident R2's Minimum Data Set (MDS - a periodic assessment of care needs) dated 5/26/24, indicated diagnoses of high blood pressure, hemiplegia (paralysis on one side of the body), and muscle weakness. Review of a physician order dated 2/22/24, indicated the usage of bilateral upper quarter side rails for mobility and positioning every shift. Review of Resident R2's care plan dated 5/30/24, indicated restraint use: bilateral upper side rails while in bed for positioning, Resident R2 will be evaluated for restraint reduction. Interventions included complete initial restraint evaluation and reevaluate at least monthly, complete initial side rail evaluation and reevaluate at least monthly, resident and family request for bilateral upper side rails for positioning and comfort, and two top side ails while in bed for safety, security, and bed mobility for comfort and positioning. During an observation on 7/12/24, at 11:26 a.m. Licensed Practical Nurse (LPN) Employee E1 confirmed there were bilateral upper side rails on Resident R2's bed. During this observation, LPN Employee E1 stated, Resident R2 is able to use the side rails during bed mobility, he is able to hold on to the bars while care is being provided. (continued on next page)

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	07/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Seneca Place	5360 Saltsburg Road Verona, PA 15147

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 7/12/24, at 12:24 p.m. MDS Coordinator Employee E9 confirmed that Resident R2's side rails are used for mobility and positioning and are not used as restraints. During this interview, MDS Coordinator Employee E9 confirmed that Resident R2's care plan was inaccurate and should not reflect restraint usage. Review of Resident R2's clinical record on 7/12/24, at 11:00 a.m. failed to reveal an initial and ongoing assessments for side rails. During an interview on 7/12/24, at 1:20 p.m. MDS Coordinator Employee E9 confirmed that side rail assessments were not completed for Resident R2. Review of the clinical record indicated Resident R6 was admitted to the facility on [DATE]. Review of Resident R6's MDS dated [DATE], indicated diagnoses of depression, anemia (too little iron in the body causing fatigue), and post-traumatic stress disorder (a disorder in which a person has difficulty recovering after experiencing or witnessing a terrifying event). Section P, Restraints and Alarms, MDS was coded 2, side rails used daily. Review of a physician order dated 2/22/24, indicated the usage of bilateral upper quarter side rails for mobility and positioning while in bed. Review of Resident R6's care plan dated 6/21/24, indicated restraint use: bilateral upper side rails while in bed for safety, security, and positioning. Resident R6 will be evaluated for restraint reduction. Interventions included complete initial restraint evaluation and reevaluate at least monthly, and complete initial side rail evaluation and reevaluate at least quarterly. During an observation on 7/12/24, at 10:03 a.m. bilateral side rails were observed on bed. Resident R6 stated I use them to help me in bed. During an interview on 7/12/24, at 12:25 p.m. MDS Coordinator Employee E9 confirmed the upper side rails were not being used as a restraint on R6 ' s bed. During an interview on 7/12/24, at 12:27 p.m. MDS Coordinator Employee E9 confirmed there were bilateral upper side rails on Resident R6's bed for positioning and are not used as restraints. During this interview, MDS Coordinator Employee E9 confirmed that Resident R6's care plan was inaccurate and should not reflect restraint usage. Review of Resident R6's clinical record on 7/12/24, at 11:05 a.m. failed to reveal an initial and ongoing assessments for side rails. During an interview on 7/12/24, at 1:20 p.m. MDS Coordinator Employee E9 confirmed that side rail assessments were not completed for Resident R6. Review of the clinical record indicated Resident R21 was admitted to the facility on [DATE]. Review of Resident R21's MDS dated [DATE], indicated diagnoses of high blood pressure, dementia (a group of symptoms that affects memory, thinking and interferes with daily life), and muscle wasting. (continued on next page)

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	395790	A. Building B. Wing	07/12/2024

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of a physician order dated 1/31/24, indicated the usage of bilateral upper side rails. Review of Resident R21's care plan dated 5/21/24, indicated restraint use: bilateral upper side rails for comfort and positioning, Resident R21 will be evaluated for restraint reduction. Interventions included complete initial restraint evaluation and reevaluate at least monthly, complete initial side rail evaluation and reevaluate at least monthly, resident and family request for bilateral upper side rails for positioning and comfort, and two top side ails while in bed for safety, security, and bed mobility for comfort and positioning. During an observation on 7/8/24 at 10:25 a.m. no side rails were observed on Resident R21's bed. During an interview on 7/12/24, at 12:22 p.m. MDS Coordinator Employee E9 stated, Resident R2 had his bed switched over the weekend, that's why he does not currently have side rails on his bed. He did previously use the side rails for mobility and positioning, but he has been performing bed mobility well without them. During an interview on 7/12/24, at 12:22 p.m. MDS Coordinator Employee E9 confirmed that Resident R21's side rails are used for mobility and positioning and are not used as restraints. During this interview, MDS Coordinator Employee E9 confirmed that Resident R21's care plan was inaccurate and should not reflect restraint usage. Review of Resident R21's clinical record on 7/12/24, at 11:15 a.m. failed to reveal an initial and ongoing assessments for side rails. During an interview on 7/12/24, at 1:20 p.m. MDS Coordinator Employee E9 confirmed that side rail assessments were not completed for Resident R21. Review of the clinical record indicated Resident R28 was admitted to the facility on [DATE]. Review of Resident R28's Minimum Data Set (MDS - a periodic assessment of care needs) dated 5/8/24, indicated diagnoses of high blood pressure, hemiplegia (paralysis on one side of the body), and dementia. Review of Resident R28's physician order on 7/10/24, failed to include an order for the resident's bilateral upper quarter side rails. Review of Resident R28's care plan dated 6/3/24, indicated positioning bars on bed-upper 1/4 rails at son's request. During an interview on 7/12/24, at 9:54 a.m. the DON confirmed Resident R28 did not have an order for bed rails and the facility failed to complete bed rail assessment. Review of the clinical record indicated Resident R64 was admitted to the facility on [DATE]. Review of Resident R64's MDS dated [DATE], indicated diagnoses of high blood pressure, diabetes (a metabolic disorder in which the body has high sugar levels for prolonged periods of time), and cerebral palsy (group of disorders that affect a person's ability to move and maintain balance and posture). Section P, Restraints and Alarms, MDS was coded 2, side rails used daily. (continued on next page)

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	395790	A. Building B. Wing	07/12/2024

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of a physician order dated 3/1/24, indicated the usage of bilateral upper quarter side rails. During an observation on 7/8/24, at 10:10 a.m. bilateral upper side rails were observed on Resident R64 ' s bed. Resident R64 stated I use them to help me move in bed. Review of Resident R64's care plan dated 5/10/24, indicated restraint use: bilateral upper side rails related to need for bed mobility. Resident R64 will be evaluated for restraint quarterly. Evaluate and record continuing risks and benefits of restraint, alternatives to restraint, need for ongoing use, and reason for restraint use. During an observation on 7/12/24, at 10:03 a.m. bilateral side rails were observed on bed. Resident R64 stated I use them to help me in bed. During an interview on 7/12/24, at 12:25 p.m. MDS Coordinator Employee E9 confirmed the upper side rails were not being used as a restraint on R64 ' s bed. During an interview on 7/12/24, at 12:27 p.m. MDS Coordinator Employee E9 confirmed there were bilateral upper side rails on Resident R6's bed for positioning and are not used as restraints. During this interview, MDS Coordinator Employee E9 confirmed that Resident R64's care plan was inaccurate and should not reflect restraint usage. Review of Resident R64's clinical record on 7/12/24, at 11:05 a.m. failed to reveal an initial and ongoing assessments for side rails. During an interview on 7/12/24, at 1:20 p.m. MDS Coordinator Employee E9 confirmed that side rail assessments were not completed for Resident R64. 28 Pa. Code: 201.14 (a) Responsibility of licensee. 28 Pa. Code: 211.12 (d) (1)(3)(5) Nursing services. 28 Pa. Code 211.10(c)(d) Resident care policies.

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	07/12/2024

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45577 Based on review of facility policies and clinical records, observations and staff interviews, it was determined that the facility failed to maintain a medication error rate of less than five percent for one of three residents (Resident R51). Findings include: The observations listed below revealed seven medication errors out of 26 opportunities resulting in a medication error rate of 25%. Review of facility policy Administering Mediations through an Enteral Tube dated 5/18/24, indicated the purpose of this procedure is to provide guidelines for the safe administration of medications through an enteral tube (a tube inserted through the wall of the abdomen into the stomach and can be used to provide liquid food, medications or liquids). General guidelines include administer each medication separately and flush between medications. . Review of Resident R51's clinical record indicated resident was admitted to the facility on [DATE]. Review of Resident R51's Minimum Data Set (MDS - periodic assessment of care needs) dated 5/2/24, indicated diagnoses of hypertension (high blood pressure in the arteries), diabetes (a metabolic disorder in which the body has high sugar levels for prolonged periods of time), and cerebral infarction (necrotic tissue in the brain resulting loss of blood and oxygen to the brain). Section K0520, Nutritional Approaches indicated use of a feeding tube. Review of Resident R51's physician orders on 7/10/24, at 8:45 a.m. indicated: Aspirin 81 mg one time a day for coronary artery disease (damage or disease in the heart's major blood vessels) Duloxetine 30 mg one time a day for depression Flomax 0.4mg one time a day for Urinary Retention Repaglinide 1 mg three times a day for Diabetes FiberLaxative one tab one time a day for supplement Losartan Potassium 50 mg one time a day for hypertension Metoprolol 50 mg twice a day for hypertension (continued on next page)

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	395790	A. Building B. Wing	07/12/2024

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation of Resident R51's medication administration on 7/10/24, at 8:15 a.m. with Registered Nurse (RN) Employee E15 indicated she crushed medications after verifying them, put them all into a medication cup and took them into resident's room. During an observation of Resident R51's medication administration on 7/10/24, at 8:16 a.m. with RN Employee E15 indicated that she administered medications together via enteral feeding tube and flushed tube afterwards. During an interview on 7/10/24, at 8:20 a.m. RN Employee E15 confirmed that she gave Resident R51's medications together instead of one by one and failed to flush in between medications. During an interview on 7/10/24, at 3:15 p.m. the Director of Nursing confirmed the facility failed to maintain a medication error rate of less than five percent for one of three residents (Resident R51). 28 Pa. Code 211.12(d)(1)(5) Nursing services.

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	395790	A. Building B. Wing	07/12/2024

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45577 Based on review of facility policy, clinical record review, observation and staff interview it was determined the facility failed to ensure that residents were free from any significant medication errors for one of three residents. (Resident R51). Findings include: Review of facility policy Administering Mediations through an Enteral Tube dated 5/18/24, indicated the purpose of this procedure is to provide guidelines for the safe administration of medications through an enteral tube (a tube inserted through the wall of the abdomen into the stomach and can be used to provide liquid food, medications or liquids). General guidelines include administer each medication separately and flush between medications. . Review of Resident R51 ' a clinical record indicated resident was admitted to the facility on [DATE]. Review of Resident R51's Minimum Data Set (MDS - periodic assessment of care needs) dated 5/2/24, indicated diagnoses of hypertension (high blood pressure in the arteries), diabetes (a metabolic disorder in which the body has high sugar levels for prolonged periods of time), and cerebral infarction (necrotic tissue in the brain resulting loss of blood and oxygen to the brain). Section K0520, Nutritional Approaches indicated use of a feeding tube. Review of Resident R51's physician orders on 7/10/24, at 8:45 a.m. indicated: Aspirin 81 mg one time a day for coronary artery disease (damage or disease in the heart's major blood vessels) Duloxetine 30 mg one time a day for depression Flomax 0.4mg one time a day for Urinary Retention Repaglinide 1 mg three times a day for Diabetes FiberLaxative one tab one time a day for supplement Losartan Potassium 50 mg one time a day for hypertension Metoprolol 50 mg twice a day for hypertension During an observation of Resident R51's medication administration on 7/10/24, at 8:15 a.m. with Registered Nurse (RN) Employee E15 indicated she crushed medications after verifying them, put them all into a medication cup and took them into resident's room. (continued on next page)

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	395790	A. Building B. Wing	07/12/2024

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation of Resident R51's medication administration on 7/10/24, at 8:16 a.m. with RN Employee E15 indicated that she administered medications together via enteral feeding tube and flushed tube afterwards. During an interview on 7/10/24, at 8:20 a.m. RN Employee E15 confirmed that she gave Resident R51's medications together instead of one by one and failed to flush in between medications. During an interview on 7/10/24, at 3:15 p.m. the Director of Nursing confirmed that the facility failed to ensure that residents were free from any significant medication errors for one of three residents. (Resident R51). 28 Pa. Code 211.12(d)(1)(5) Nursing services.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48546 Based on review of facility policies, observations, and staff interviews, it was determined that the facility failed to properly store medications in two out of five medication carts (3 East Medication Cart and 4 East Medication Cart), failed to monitor refrigerator temperatures utilized for medication storage in one of two nursing units (Fourth Floor Medication Room), and failed to properly secure a medication cart while not in use for one of five medications carts (2 North Medication Cart). Findings include: Review of facility policy Storage of Medications dated 5/18/24, indicated the facility stores all drugs and biologicals in a safe, secure, and orderly manner. Drugs and biologicals used in the facility are stored in locked compartments under proper temperature, light and humidity controls. Drugs and biologicals are stored in the packaging, containers, or other dispensing systems in which they are received. The nursing staff is responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner. Compartments containing drugs and biologicals are locked when not in use. Unlocked medication carts are not left unattended. During an observation on 7/9/24, at 8:32 a.m. of the 3 [NAME] Medication Cart indicated the following medications stored in one compartment without individual packaging or separation from other residents medications and without proper labeling: - Resident R5's aspart insulin pen (a prefilled pen to inject rapid-acting insulin under the skin), with the resident's last name written on the cap with a black marker. - Resident R335's lispro insulin pen (a prefilled pen to inject rapid-acting insulin under the skin), with the resident's last name written on the cap with a black marker. Continued observations of the 3 [NAME] Medication Cart revealed the following medications not dated upon opening: - Resident R5's aspart insulin pen, no date opened. - Resident R68's Lantus pen (a prefilled pen to inject long acting insulin under the skin), no date opened. - Resident R335's Lantus pen, no date opened. - Resident R335's lispro insulin pen, no date opened. During an interview on 7/9/24, at 8:45 a.m. Licensed Practical Nurse (LPN) Employee E3 confirmed the above observations. (continued on next page)

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	395790	A. Building B. Wing	07/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 7/10/24, at 8:18 a.m. the 2 North Medication Cart was observed outside of resident room [ROOM NUMBER] with the cart unlocked and unattended. During an interview on 7/10/24, at 8:20 a.m. Registered Nurse Employee E15 confirmed 2 North Medication Cart was unlocked and unattended. During an observation of the Fourth Floor Medication Room on 7/11/24, at 8:23 a.m. failed to reveal a temperature log for a medication refrigerator containing unopened prefilled insulin pens. During an interview on 7/11/24, at 8:26 a.m. LPN Employee E8 confirmed that the refrigerator in the Fourth Floor Medication Room did not have a temperature log. During an observation on 7/11/24, at 8:44 a.m. of the 4 East Medication Cart revealed the following medications stored in one compartment without individual packaging or separation from other residents medications and without proper labeling: - Resident R241's Lantus pen, with the resident's last name written on the cap with a black marker. During an interview on 7/11/24, at 8:48 a.m. LPN Employee E10 confirmed the above observation. During an interview on 7/11/24, at 2:58 p.m. the Director of Nursing confirmed that the facility failed to properly store medications in two out of five medication carts (3 East Medication Cart and 4 East Medication Cart), failed to monitor refrigerator temperatures utilized for medication storage in one of two nursing units (Fourth Floor Medication Room), and failed to properly secure a medication cart while not in use for one of five medications carts (2 North Medication Cart). 28 Pa. Code: 211.9(a)(1)(h)(k)(l)(1) Pharmacy services. 28 Pa. Code:211.12(d)(1)(2)(3)(5) Nursing services.

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	07/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Seneca Place	5360 Saltsburg Road Verona, PA 15147

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 46167 Based on review of facility policy, observations and staff interview, it was determined the facility failed to properly store food products in a manner to prevent foodborne illness in the Main Kitchen. Findings include: Review of facility policy Food Receiving and Storage dated 5/18/24, indicated foods shall be received and stored in a manner that complies with safe food handling practices. Opened containers must be dated and sealed or covered during storage. During an observation on 7/8/24, at 9:36 a.m. in the Main Kitchen Dry storage area, an open box contained a plastic bag of rice that was not sealed, and an additional open box that contained a plastic bag of pureed bread mix that also was not sealed. During an interview on 7/8/24, at 9:45 a.m. Dietary Director Employee E13 confirmed that the facility failed to properly store products in a manner to prevent foodborne illness. 28 Pa. Code: 201.14(a) Responsibility of licensee 28 Pa. Code: 201.18(b)(1) Management. 28 Pa. Code: 211.6(c) Dietary services.

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	07/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48546 Based on clinical record review and staff interview, it was determined that the facility failed to maintain complete and accurate documentation for three of 16 residents (Resident R4, R9, and R38). Findings include: 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. Documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate. Review of Title 42 Code of Federal Regulations (CFR) S483.709(i) Medical records. In accordance with accepted professional standards and practice, the facility must maintain medical records that are complete, accurately documented, readily accessible, and systematically organized. Review of the clinical record indicated that Resident R4 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Residents R4's Minimum Data Set (MDS - a periodic assessment of care needs) dated 5/8/24, indicated diagnoses of depression, high blood pressure, and diabetes a group of diseases that affect how the body uses blood sugar (glucose). Review of Resident R4's physician order dated 3/20/24, indicated to complete a skin check weekly every evening shift every Monday for monitoring. Review of a Skin/Wound Note 6/20/24, revealed that the note was entered by Wound Care Nurse Employee E4 on 7/9/24, at 10:21 a.m. Review of a Skin/Wound Note dated 6/27/24, revealed that the note was entered by Wound Care Nurse Employee E4 on 7/9/24, at 10:23 a.m. During an interview on 7/12/24, at 8:47 a.m. the Director of Nursing confirmed the facility did not maintain complete and accurate documentation for Resident R4. Review of the clinical record indicated that Resident R9 was admitted to the facility on [DATE]. Review of Residents R9's MDS dated [DATE], indicated diagnoses of multiple sclerosis (a potentially disabling disease of the brain and spinal cord (central nervous system), depression, and osteoarthritis (occurs when the protective cartilage that cushions the ends of the bones wears down over time.) Section M: Skin Conditions, indicated Resident R9 was at risk of pressure ulcer development, and at the time of her assessment the resident had one Stage three pressure ulcer (full-thickness skin loss potentially extending into the subcutaneous tissue layers of the skin). (continued on next page)

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	07/12/2024

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of a physician order dated 2/27/24, indicated to complete a skin check weekly every evening shift every Tuesday for monitoring. Review of Resident R9's Skin and Wound Evaluation V7.0 dated 6/27/24, indicated the resident had a stage 2(characterized by partial-thickness skin loss into but no deeper than the dermis (the second and thickest layer of the three major layers of skin)) pressure ulcer that measured 2.2 cm x 2.1 cm x 1.4 cm. It was indicated the surrounding tissue had black/blue discoloration. It stated the resident's pressure ulcer was almost healed and then the resident developed a Deep tissue Injury (DTI-a type of subcutaneous tissue damage that results from an externally applied mechanical pressure) on new periwound skin (refers to tissue surrounding a wound). The facility failed to accurately stage Resident R9's pressure ulcer. During an interview on 7/10/24, at 10:56 a.m. the DON confirmed the facility failed to accurately stage and document Resident R9's pressure ulcer. During an interview on 7/10/24, at 11:40 a.m. Wound Care Registered Nurse, Employee E4 stated a stage three pressure ulcer you would see bone and tendon and a stage 2 pressure ulcer is an opening of the skin to the tissue or muscle, that doesn't reach the bone. Review of the clinical record indicated Resident R38 was admitted to the facility on [DATE]. Review of Resident R38's MDS dated [DATE], indicated diagnoses of high blood pressure, dementia (a group of symptoms that affects memory, thinking and interferes with daily life), and muscle wasting. Review of the clinical record revealed that Resident R38 had a stage three pressure ulcer (a skin and tissue injury that extends through the skin and into deeper tissue and fat, but does not reach muscle, tendon, or bone) to her right heel. Review of a Skin/Wound Note dated 7/5/24, revealed that the note was entered by Wound Care Nurse Employee E4 on 7/9/24, at 10:10 a.m. Review of a Skin/Wound Note 6/27/24, revealed that the note was entered by Wound Care Nurse Employee E4 on 7/9/24, at 10:07 a.m. During an interview on 7/9/24, at 2:11 p.m. Wound Care Nurse Employee E4 stated, There is a delay in my documentation because I am doing three jobs at once. I have a bunch of scratch papers in my piles, I write weekly wound measurements down on those, but sometimes it will sit there because I'm backlogged. I do not feel like I can do all of these tasks. During an interview on 7/9/24, at 2:11 p.m. Wound Care Nurse Employee E4 confirmed that the facility failed to maintain complete and accurate documentation for Resident R38. Review of Resident R38's Weekly Skin Integrity Review revealed documentation indicating that Resident R38's skin was documented as intact for nine of 13 weeks on 4/12/24, 4/21/24, 5/6/24, 5/20/24, 5/27/24, 6/4/24, 6/11/24, 6/18/24, and 7/10/24. (continued on next page)

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	395790	A. Building B. Wing	07/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Seneca Place	5360 Saltsburg Road Verona, PA 15147

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 7/10/24, at 11:40 a.m. Wound Care Nurse Employee E4 stated, Staff should be documenting that skin is not intact, she has a pressure ulcer. During an interview on 7/10/24, at 11:40 a.m. Wound Care Nurse Employee E4 confirmed that the facility did not maintain accurate documentation for Resident R38. 28 Pa. Code 211.5(f) Clinical Records. 28 Pa. Code 211.12(d)(1)(5) Nursing services.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48546 Based on a review of facility policy, resident clinical records, and staff interview, it was determined the facility failed to obtain a diagnosis for hospice services and to ensure the coordination of hospice services with facility services to meet the needs of each resident for end of life care for two of two residents (Resident R38 and R93). Findings include: Review of facility policy Hospice Program dated 5/18/24, indicated it is the responsibility of the facility to meet the resident's personal care and nursing needs in coordination with the hospice representative, and ensure that the level of care provided is appropriately based on the individual resident's needs, including communicating with the hospice provider (and documenting such communication) to ensure that the needs of the resident are addressed and met 24 hours per day. The coordinated care plan will reflect the resident's goals and wishes, as stated in his or her advanced directives and during ongoing communication with the resident or representative. Review of the clinical record indicated Resident R38 was admitted to the facility on [DATE]. Review of Resident R38's Minimum Data Set (MDS - a periodic assesssment of care needs) dated 4/7/24, indicated diagnoses of high blood pressure, dementia (a group of symptoms that affects memory, thinking and interferes with daily life), and muscle wasting. Review of a physician order dated 1/28/24, indicated to admit Resident R38 to hospice, but did not include a diagnosis related to the need of hospice services. During an interview on 7/8/24, at 10:48 a.m. Health Unit Coordinator (HUC) Employee E22 confirmed Resident R38 receives hospice services on Mondays and Wednesdays. Review of Resident R38's current comprehensive care plan failed to indicate a plan of care by the facility that displayed the coordination of hospice services by failing to included contact information for the hospice agency and how to access the hospice's 24 hour on-call system. Review of clinical record revealed that Resident R93 was admitted to the facility on [DATE]. Review of Resident 93's MDS dated [DATE], indicated diagnoses of high blood pressure, chronic kidney disease, and hyponatremia (low sodium level in the blood). Section O0100 question K1 indicated that Resident R93 has received hospice care while a resident. Review of clinical record revealed a physician's order dated 3/15/24, to admit Resident R93 to hospice. Review of the above physician's order did not include a diagnosis related to the need of hospice services. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/8/24, at 2:10 p.m. Resident R93 confirmed that she receives hospice services. Review of Resident R93's current comprehensive care plan failed to indicate a plan of care by the facility that displayed the coordination of hospice services by failing to included contact information for the hospice agency and how to access the hospice's 24 hour on-call system. During an interview on 7/12/24, at 11:51 a.m. the Director of Nursing confirmed the facility failed to obtain a diagnosis for hospice services and to ensure the coordination of hospice services with facility services to meet the needs of each resident for end of life care for two of two residents (Resident R38 and R93). 28 Pa. Code 211.2(a) Physician services. 28 Pa. Code 211.11(d) Resident care plan.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48546 Based on review of facility policy, resident records, observations and staff interview it was determined that the facility failed to implement an infection control program that included a system of surveillance to identify possible communicable diseases or infections for four of 11 months (March 2024, April 2024, May 2024, and June 2024), failed to prevent cross contamination during a dressing change for one of two residents (Resident R9), and failed to make certain that appropriate treatments and services were provided for the use of a urinary catheter as required for one out of five residents (R53). Findings include: Review of facility policy Surveillance for Infections dated 5/18/24, indicated the Infection Preventionist will conduct ongoing surveillance for Healthcare-Associated Infections (HAIs) and other epidemiologically significant infections that have substantial impact on potential resident outcomes and that may require transmission-based precautions and other preventative interventions. The purpose of the surveillance of infections is to identify both individual cases and trends of epidemiologically significant organisms and HAIs, to guide appropriate interventions, and to prevent future infections. Review of the Quality Assurance/Infection Control Preventionist job description indicated responsibilities include develops and implements an ongoing infection prevention control program to prevent, recognize, and control the onset and spread of infections to provide a safe, sanitary, and comfortable environment, and maintains documentation of infection prevention and control program activities. Review of the facility policy Wound Care dated 5/18/24, indciated that the purpose of this policy is to provide guidelines for the care of wounds to promote healing. Step one indicated to use disposable cloth (paper towel is adequate) to establish a clean field on the resident's bedside table. Place all items to be used during procedure on the clean field. Once completed with the dressing change, clean the bedside table, and return it to it's proper position. Review of facility policy Catheter Care, Urinary dated 5/18/24, indicated that the facility should ensure that the catheter tubing and drainage bag are kept off the floor. Review of facility policy Infection Control dated 5/18/24, states the facility's infection control policies and practices are intended to facilitate maintaining a safe, sanitary, and comfortable environment and to help prevent and manage transmission of diseases and infection. Review of the facility's Infection Control documentation for the previous 11 months (August 2023 through June 2024) failed to reveal surveillance for tracking infections for residents for four of 11 months (March 2024, April 2024, May 2024, and June 2024). During an interview on 7/12/24, at 8:50 a.m. the Director of Nursing (DON) confirmed that the facility failed to implement an infection control program that included a system of surveillance to identify possible communicable disease or infections for four of 11 months (March 2024, April 2024, May 2024, and June 2024). (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the clinical record indicated that Resident R9 was admitted to the facility on [DATE]. Review of Residents R9's Minimum Data Set (MDS - a periodic assessment of care needs) dated 2/9/24, indicated diagnoses of multiple sclerosis (a potentially disabling disease of the brain and spinal cord (central nervous system), depression, and osteoarthritis (occurs when the protective cartilage that cushions the ends of the bones wears down over time.) Review of Resident R9's physician order dated 5/28/24, indicated to cleanse the left heel with vashe (wound cleanser), apply collagen paste (a wound paste that contains protein that plays a role in each phase of wound healing and encourages new tissue growth), mix small amount of normal saline solution with powder to form paste, and cover with abdominal pad (wound dressing used for wounds requiring high absorbency) and kerlix (rolled gauze commonly used to wrap extremity wounds) daily for wound care. During an observation of Resident R9's left heel dressing change on 7/10/24, at 9:32 a.m. Wound Care Registered Nurse, Employee E4 failed to wash her hands prior to putting on gloves, failed to clean the bedside table prior to placing a barrier on half of the table. The bottom of the pack of gauze was placed off the clean barrier, and Wound Care RN, Employee E4 placed the pack of gauze back on the clean field. Wound Care RN, Employee E4 placed scissors on the unclean bedside table and failed to clean them prior to removing Resident R9's old dressing. Once Wound Care RN, Employee E4 completed Resident R9's dressing change, she failed to clean the bedside table. During an interview on 7/10/24, at 10:56 a.m. the Director of Nursing confirmed the facility failed to prevent cross contamination during a dressing change for one of five residents (Resident R9). Review of Resident R53's clinical record indicated the resident was admitted to the facility on [DATE]. Review of Resident R53's MDS dated [DATE], indicated diagnoses of spina bifida (a birth defect in which a spinal cord fails to develop properly), hypertension (high blood pressure in the arteries), and depression. Section H-Bladder and Bowel indicated the utilization of an urostomy (a surgical procedure that creates a stoma for the urinary system). Review of the clinical record revealed that Resident R53 had a physician's order dated 3/8/24, for urostomy care. During an observation on 7/8/24, at 10:30 a.m. Resident R53 was observed lying in bed with his urinary catheter bag laying directly on the floor without a covering bag. During an interview on 7/8/24, at 10:36 a.m. Licensed Practical Nurse Employee E14 stated, I'll take care of that now. During an interview on 7/8/24, at 3:15 p.m. the DON confirmed that the facility failed to make certain that appropriate treatments and services were provided for the use of a urinary catheter as required for one out of five residents (R53). 28 Pa. code: 201.14 (a) Responsibility of licensee. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	28 Pa. Code: 201.18 (b) (1) (e) (1) Management. 28 Pa. Code: 211.10 (d) Resident care policies. 28 Pa. Code: 211.12 (d) (1) (2) (5) Nursing services.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement a program that monitors antibiotic use. 48546 Based on review of the facility's infection control policies and procedures and staff interview, it was determined that the facility failed to implement an antibiotic stewardship program for three of 11 months (March 2024, April 2024, May 2024, and June 2024). Findings include: Review of facility policy Antibiotic Stewardship dated 5/18/24, indicated the purpose of the Antibiotic Stewardship Program is to monitor the use of antibiotics in our residents. Review of the Quality Assurance/Infection Control Preventionist job description indicated responsibilities include overseeing the community's antibiotic stewardship program. Review of the facility's Infection Control surveillance for August 2023 through June 2024, failed to include documentation to indicate that antibiotic monitoring was completed for March 2024, April 2024, May 2024, and June 2024. During an interview on 7/12/24, at 8:50 a.m. the Director of Nursing confirmed that the facility failed to implement an antibiotic stewardship program for four of 11 months (March 2024, April 2024, May 2024, and June 2024). 28 Pa. Code: 211.10(c)(d) Resident care policies. 28 Pa. Code: 211.12(d)(1)(2)(3)(5) Nursing services.

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. 45577 Based on review of facility in-service documentation, personnel records, and staff interviews it was determined that the facility failed to ensure that all nurse aide staff received a minimum of twelve hours of in-service education training each year, within 12 months of their hire date anniversary, as required for five out of five personnel records (Nurse Aide Employee E17, Nurse Aide Employee E18, Nurse Aide Employee E19, Nurse Aide Employee E20, and Nurse Aide Employee E21). Findings include: Review of facility policy titled Staffing, Sufficient and Competent Nursing, dated 5/18/24, indicated that the facility provides sufficient numbers of nursing staff with the appropriate skills and competency necessary to provide nursing and related care and services for all residents in accordance with resident care plans and the facility assessment. Review of Nurse Aide Employee E17's personnel record indicated she was hired on 1/30/06. Review of Nurse Aide Employee E17's personnel record failed to include a minimum of 12 hours of nurse aide training per year as required under S483.95(g)(1). Review of Nurse Aide Employee E18's personnel record indicated she was hired on 11/20/22. Review of Nurse Aide Employee E18's personnel record failed to include a minimum of 12 hours of nurse aide training per year as required under S483.95(g)(1). Review of Nurse Aide Employee E19's personnel record indicated she was hired on 8/15/22. Review of Nurse Aide Employee E19's personnel record failed to include a minimum of 12 hours of nurse aide training per year as required under S483.95(g)(1). Review of Nurse Aide Employee E20's personnel record indicated she was hired on 9/4/23. Review of Nurse Aide Employee E20's personnel record failed to include a minimum of 12 hours of nurse aide training per year as required under S483.95(g)(1). Review of Nurse Aide Employee E21's personnel record indicated she was hired on 10/24/22. Review of Nurse Aide Employee E21's personnel record failed to include a minimum of 12 hours of nurse aide training per year as required under S483.95(g)(1). During an interview on 7/12/24, at 2:27 p.m., the Nursing Home Administrator revealed that the facility was unable to provide documentation that 12 hours of annual in-service training was completed for Nurse Aide Employees E17, E18, E19, E20, and E21, within 12 months of their hire date anniversary. (continued on next page)

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 7/12/24, at 2:30 p.m., the Nursing Home Administrator (NHA) confirmed that the facility failed to ensure that all nurse aide staff received a minimum of twelve hours of in-service education training each year for five out of five personnel records (Nurse Aide Employee E17, Nurse Aide Employee E18, Nurse Aide Employee E19, Nurse Aide Employee E20, and Nurse Aide Employee E21). 28 Pa. Code: 201.14(a) Responsibility of Licensee. 28 Pa. Code: 201.20(a)(d) Staff Development.