STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395795	A. Building B. Wing	05/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lafayette Manor, Inc	147 Lafayette Manor Road Uniontown, PA 15401

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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from the wrongful use of the resident's belongings or money. 39311 Based on a review of facility policy, clinical records, and incident investigation documents, it was determined that the facility failed to ensure that residents are free from misappropriation of property for 12 of 15 residents (Resident R1, R2, R3, R4, R, R6, R7, R8, R9, R10, R11, R12). This was identified as past non-compliance. Findings include: Review of the facility Abuse Prevention Policy and Procedure dated 8/17/23, indicated that the facility will assure that the resident is free from misappropriation of property, which the policy defined as, the deliberate misplacement, exploitation, or wrongful, temporary or permanent use of resident's belongings or money without the resident's consent. Review of facility investigation of medications signed out by LPN Employee E1 form 5/10/24, at 1:45 p.m. through 5/11/24, at 7:15 a.m. revealed the following: -Resident R1 had three pills of oxycodone/apap (commonly referred to as Percocet, an opioid pain medication used to treat moderate to moderately severe pain) 7.5/3.5 mg signed out, but not administered. -Resident R2 had two pills of tramadol (commonly referred to as Ultram, an opioid pain medication used to treat moderate to severe pain) 50 mg signed out, but not administered. -Resident R3 had one pills of tramadol 50 mg signed out, but not administered and three pills of hydrocodone/APAP (commonly referred to as Vicodin, an opioid pain medication used to treat moderate to severe pain) 5/325 singed out, but not administered. -Resident R4 had three pills of oxycodone IR (an immediate release opioid pain medication used to treat moderate to severe pain) 5 mg signed out, but not administered. -Resident R5 had one pill of tramadol 50 mg signed out, but not administered. -Resident R6 had one pill of oxycodone IR 5 mg signed out, but not administered. -Resident R7 had one pill of tramadol 50 mg signed out, but not administered. (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

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Resident R8 had one pill of tramadol 50 mg signed out, but not administered. -Resident R9 had one pill of oxycodone IR 5 mg signed out, but not administered. -Resident R10 had two pills of tramadol 50 mg signed out, but not administered. -Resident R11 had one pill of tramadol 50 mg signed out, but not administered. -Resident R12 had one pills of hydrocodone/APAP 5/325 singed out, but not administered. Review of the facility investigation summary indicated On 5/11/24, the Director of Nursing (DON) and Nursing Home Administrator (NHA) were notified of controlled medication discrepancies involving one resident. DON and nursing supervisors conducted an audit of controlled substance documentation and identified 21 discrepancies involving 12 residents from 5/1024, through 5/11/24, with one LPN (licensed practical nurse) identified as not completing documentation on EMAR (electronic medication administration record)but signed off on controlled substance count sheet. Five alert and oriented residents were interviewed by nursing supervisor, four residents reported that they did not receive pain medications. One resident was unsure if received pain medications. DON contacted LPN in question on 5/11/24, LPN was not able to come to facility on this date. State police notified and conducted an investigation. Residents were interviewed by police. The conclusion of the investigation revealed, LPN suspended until investigation completed. Terminated from position. State board of licensure was notified, scheduled to come to facility for investigation. On 5/11/24, the facility initiated a plan of correction that included: -Suspension and subsequent termination of LPN Employee E1. -State board of licensure notified. -Abuse, neglect, misappropriation, exploitation education completed for all staff members. -Human Resources director completed audit of new hire abuse training. -Facility audit of controlled substance documentation. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of an employee statement written by Registered Nurse (RN) Employee E2 dated 5/11/24, indicated, On 5/11/24, I was assigned as RN supervisor. [RN Employee E3] brought to my attention that the nurse working the previous shift [LPN Employee E1], signed out a narcotic from the control drug record on the 1st floor blue cart but did not sign it out as administered in the eMar. As [RN Employee E3] and I looked through her controlled drug record we discovered that multiple narcotics were signed out by [LPN Employee E1] 5/10 - 5/11 and not documented in the eMar. [LPN Employee E1] had worked the previous two shifts on the 1st floor (5/10/24, at 1:45 p.m. to 5/11/24, at 7:15 a.m.). LPN Employee E4 was working on the 1st floor green cart and identified the same concern that [LPN Employee E1] signed out narcotics from the control drug record but not the eMar during the same time frame 5/10-5/11. Suspecting narcotic diversion, I notified the DON who advised that I notify the state police immediately and she would be at the facility to continue investigating. I called the state police. Trooper arrived to investigate and interviewed five alert and oriented residents in my presence, that all had narcotics signed out of the narcotic drug record but not the eMar. All residents were agreeable to speaking with the Trooper. Residents were [Resident R4, R12, R2, R3, and R13]. Trooper asked the residents if they requested or were given the specific medication, one resident [Resident R13] said I don't know. DON arrived at the facility and continued the investigation. Review of an employee statement written by RN Employee E3 dated 5/11/24, indicated, I was passing medications at approximately 8:00 a.m. when I noticed that a narcotic for a resident was signed out in the narcotic book but was not signed that it was given in Point Click Care, (PCC, the electronic charting system). I continued my med pass and again notice that another narcotic on another residents was signed out in the narcotic book bot not in PCC. At that time I thought it best to check each of the resident's narcotics to look for the same discrepancy. That is when I noticed the same occurrence on multiple residents. I made my supervisor aware and we spoke with some of the residents whose medications were involved. At that time the police were notified along with the DON. The conclusion of the investigation was documented, LPN suspended until investigation completed. Terminated from position. State board of licensure was notified, scheduled to come to facility for investigation. On 5/11/24, the facility initiated a plan of correction that included: -Suspension and subsequent termination of LPN Employee E1. -State board of licensure notified. -Human Resources director completed audit of new hire abuse training. -Facility comprehensive audit of controlled medication administration for all residents. -Pain assessments completed for residents identified with medication discrepancies. -Education of controlled substance policy and medication administration policy to licensed nursing staff. -Abuse, neglect, misappropriation, exploitation education completed for all staff members. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Ad hoc QAPI (Quality Assurance and Performance Improvement) meeting conducted to review findings and identify additional actions necessary. -Controlled substance audits initiated, five times per week. During interviews completed on 5/17/24, seven staff members confirmed that they were provided abuse, neglect and misappropriation education. During interviews completed on 5/17/24, three licensed nursing staff confirmed they were provided controlled substance policy and medication administration policy education. During an interview on 5/21/24, at 4:30 p.m. the Nursing Home Administrator confirmed that the facility failed to ensure that residents are free from misappropriation of property for 12 of 15 residents who are ordered controlled medications. 28 Pa. Code 211.5(f)(g) Clinical records. 28 Pa. Code 211.9(a)(1)(k) Pharmacy services. 28 Pa. Code 211.12(a)(c)(d)(1)(3)(5) Nursing services.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
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** 39311 Based on review of facility policy, clinical record review, and resident and staff interview, it was determined that the facility failed to follow physician orders for medication administration for one of five residents reviewed (Resident R14). Findings include: Review of the facility's policy, Administering Medications, dated 8/17/23, indicated that medications shall be administered in a safe and timely manner, and as prescribed. Review of the clinical record indicated Resident R14 was admitted to the facility on [DATE]. Review of the Minimum Data Set (MDS - periodic assessment of resident care needs) dated 5/10/24, included the diagnoses of anemia (too little iron in the body causing fatigue), chronic kidney disease (gradual loss of kidney function), and cancer. Review of Section O: Special Treatments, Procedures, and Programs revealed the Resident R14 had received chemotherapy within the previous 14 days of the assessment. Review of Resident R14's medication administration record (MAR) dated April 2024, revealed the following: 4/2/24, 2:00 p.m. Gabapentin (nerve pain): documented as 9 (9 is code for Other/See Nurse Notes). 4/2/24, 2:00 p.m. Rytary (Parkinson's): documented as 9. Review of the associated progress note dated 4/2/24, at 3:48 p.m. indicated, Has not returned from chemo yet. Review of a progress note dated 4/2/24, at 4:44 p.m. indicated, Resident returned from chemo at this time. Further review of Resident R14's physician orders, MAR, and progress notes failed to reveal if the physician had previously addressed when medications missed while the resident was out to chemotherapy should be provided, if the physician was contacted by the facility for the missed medication, and whether the resident received the missed medications. 4/9/24, 2:00 p.m. Gabapentin: documented as 3 (3 is code for Drug Refused). 4/9/24, 2:00 p.m. Rytary: documented as 3. 4/10/24, 2:00 p.m. Gabapentin: documented as 3. 4/10/24, 2:00 p.m. Rytary: documented as 3. Review of a progress note dated 4/9/24, at 3:57 p.m. indicated, Resident returned to [facility]. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a progress note dated 4/10/24, at 6:01 p.m. indicated, Returned to [facility] via wheel/chair van. Review of Resident R14's MAR dated May 2024, revealed the following: 5/7/24, 8:00 a.m. mediations (amantadine, calcium carbonate, Cholecalciferol, gabapentin, Lasix, Lexapro, and Rytary) documented as 9. Review of the associated progress note dated 4/2/24, at 3:48 p.m. indicated, NPO (meaning nothing by mouth). Review of a progress note dated 5/7/24, at 6:20 p.m. indicated, received call from [Resident R14's] daughter, daughter stated that her mother was upset because she did not receive her medications this am upon return from her PET scan, resident was out of the building from 6:50 am until 9:40 am, this nurse did speak with resident, resident told this nurse that she did not get her morning meds, med list reviewed with [Resident R14] at this time, was noted that there were four am meds that she had not received this day-Lasix, Tums, vitamin D supplement and Lexapro, all other am meds are scheduled more than once daily and she has received the afternoon and evening doses of those medications, [Resident R14] was requesting that the medications that she did not receive this am be given at this time, CRNP (Certified registered nurse practitioner) made aware and new order received to give one time dose of the four meds mentioned above. will give this evening. [Resident R14] informed, also daughter informed. During an interview on 5/17/24, at approximately 3:30 p.m. the Nursing Home Administrator confirmed that on 4/2/24, the facility failed to address if or when the medications missed while Resident R14 was at chemotherapy would be provided, confirmed that on 4/9/24, and 4/10/24, that facility staff documented that Resident R14 refused her medications while she was not in the facility to have done so, and on 5/7/24, the facility failed to address if Resident R14 could have her medications prior to her PET scan, which is often the case, and failed to address what medications could be provided upon return to the facility after the pet scan. During an interview on 5/17/24, at approximately 3:35 p.m. the Nursing Home Administrator confirmed that the facility failed to follow physician orders for medication administration for one of five residents reviewed. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 39311 Based on review of facility policy, resident observations, resident interviews and confidential staff interviews, and grievance review, it was determined that the facility failed to have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of six of twelve residents (Resident R6, R14, R15, R16, and R17). Findings Include: Review of the facility policy Activities of Daily Living dated 8/17/23, indicated Residents will be provided with care, treatment and services as appropriate to maintain or improve their ability to carry out activities of daily living (ADLs). Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene. During an interview and observation on 5/17/24, at 1:45 p.m. Resident R14 was noted to have long, jagged fingernails. When asked, Resident R14 confirmed that she would like her nails clipped. During an interview on 5/17/24, at 2:50 p.m. Resident R15 stated that call lights may be long, and on evening shift her medications are often late, depending on the nurse. During an interview on 5/17/24, at 3:06 p.m. Resident R2 stated that she only gets showers once per week, and that it is her preference to have two showers per week. Resident R2 also stated that call lights can take a while. During an interview and observation on 5/17/24, at 3:07 p.m. Resident R1 stated, when asked about call light response, It depends. Resident R1 was noted to have unbrushed, greasy-appearing hair. During an interview on 5/24/24, at approximately 10:30 a.m Resident R6 stated that she was left on the bedside commode for an hour. I was waiting and waiting and they never came after me. When asked if she had been in pain after being left so long on the commode, Resident R6 stated, Oh, yes. My butt hurt so bad. They said they had 43 people to take care of, they didn't have enough help. Review of a grievance filed by Resident R16 on 2/22/24, stated that staff were not assisting him to get out of bed for therapy and that he waited over one hour for his pain medication. Review of a grievance filed by Resident R17 on 3/11/24, stated that the nurse aide failed to provide incontinence care when requested. Resident R17 was documented to have stated that she knows facility is understaffed due to two call off this date. Resident R17 was then documented to have stated that the nurse aide does not need to take it out on her. Review of Resident Council minutes dated 2/19/24 indicated concerns about call light response. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident Council minutes dated 3/28/24 indicated concerns long waits for bathroom assistance, call lights responses of over one hour, and call lights being turned off without caring for the resident's needs. Review of Resident Council minutes dated 4/25/24, indicated concerns call lights being turned off without caring for the resident's needs. During an interview on 5/24/24, 10:00 a.m. the Nursing Home Administrator confirmed that the facility failed to have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of six of twelve residents. 28 Pa. Code: 201.14(a) Responsibility of licensee. 28 Pa. Code 201.18(e)(6) Management. 28 Pa. Code: 201.20(a) Staff development. 28 Pa. Code: 211.12(a)(c)(d)(1)(2)(3)(4) Nursing services.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39311 Based on a review of CDC (U.S. Centers for Disease Control and Prevention) documents, facility policy, clinical record review, observations and staff interviews, it was determined that the facility failed to maintain infection control procedures to prevent the possible transmission of communicable diseases for one of three residents (Resident R14). Review of the CDC document, Neutropenia and Risk for Infection dated 2/26/24, defined neutropenia as the decrease in the number of white blood cells, the body's main defense against infection, and further stated that neutropenia is common after receiving chemotherapy and increases the risk for the development of infection. The facility policy Transmission Based Precautions dated 8/17/23, indicated facility strives to maintain a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections by utilizing the least restrictive precautions or isolation for the resident under certain circumstances. Transmission-Based Precautions, in addition to Standard Precautions, are initiated when a resident develops signs and symptoms of a transmissible infection; arrives for admission with symptoms of an infection; or has a laboratory confirmed infection; and is at risk of transmitting the infection to other residents. Further review of the policy failed to include information related to neutropenic isolation precautions (precautionary steps to prevent an resident with a suppressed immune system from contracting infections from staff or visitors). Precautions can include a notice placed on the door to alert people entering the room, instructions to wash hands with soap and water and/or wearing gloves, wearing a mask, leaving reusable equipment in the room, and being given or not given specific foods. Review of the clinical record indicated Resident R14 was admitted to the facility on [DATE]. Review of the Minimum Data Set (MDS - periodic assessment of resident care needs) dated 5/10/24, included the diagnoses of anemia (too little iron in the body causing fatigue), chronic kidney disease (gradual loss of kidney function), and cancer. Review of Section O: Special Treatments, Procedures, and Programs revealed the Resident R14 had received chemotherapy within the previous 14 days of the assessment. Review of a physician's order dated 4/22/24, indicated Neutropenic Precautions. Review of Resident R14's plan of care initiated on 2/26/24, indicated Resident R14 has a diagnosis of breast cancer and was receiving chemotherapy. Further review of her care plan failed to include information related to neutropenic precautions. Review of Resident R14's Kardex (document that outlines the patients' ADLs, continence levels, and behaviors, as well as physician, advanced directives, diet, and allergies) utilized by nurse aide staff dated 5/17/24, failed to include information related to neutropenic precautions. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 5/17/24, at 1:45 p.m. signage was posted on Resident R14 door indicating the need to wear gloves and a mask. A set of plastic drawers were located in the hallway next to Resident R14's door. Observation of the drawers revealed there were only clear face shields available, no gloves or masks. During an interview on 5/17/24, at 1:46 p.m. LPN Employee E5 confirmed that she was aware that neutropenic precautions are to prevent transmission of infection to the resident, not from the residents, and further confirmed that a face shield would not be effective to prevent the transmission of infection and that gloves and masks were not available at Resident R14's doorway. During an observation on 5/17/24, at 2:43 p.m. Nurse Aide Employee E6 was observed entering Resident R14's room without wearing gloves or a mask. During an interview on 5/21/24, at the Nursing Home Administrator confirmed the facility failed to maintain infection control procedures to prevent the possible transmission of communicable diseases for one of three residents. 28 Pa. Code: 211.10(d) Resident care policies. 28 Pa. code: 211.12(d)(1)(5) Nursing services.