STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395823	A. Building B. Wing	10/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Townview Health and Rehabilitation Center	300 Barr Street Canonsburg, PA 15317

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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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 49646 Based on review of the facility policy and clinical records and staff interviews, it was determined that the facility failed to provide the opportunity to formulate an advance directive (written instructions such as a living will or durable power of attorney for health care for when the individual is incapacitated) for thirteen of the eighteen residents reviewed (Resident R5, R19, R25, R27 R30, R46, R51, R52, R59, R60, R64, R86, R87). Findings include: A review of the facility policy Advanced Directives last reviewed 3/27/24, indicated the facility will comply with the requirements related to maintaining written policies and procedures regarding advance directives, including provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and formulate an advance directive. A review of the medical record indicated Resident R5 was readmitted to the facility on [DATE], with diagnoses that included diabetes, dementia (decline in the ability to perform everyday activities), gastro-esophageal reflux disease (GERD-severe heartburn), transient ischemic attack (brief stroke-like attack that can have weakness on one side, slurred speech, vision problems-resolves in minutes to hours). A review of the clinical record failed to reveal and advance directive or documentation that Resident R5 was given the opportunity to formulate an Advanced Directive. A review of the clinical record indicated Resident R19 was readmitted to the facility on [DATE], with diagnoses that include chronic obstructive pulmonary disease (group of lung diseases that block airflow and make it difficult to breathe), anxiety, obstructive and reflux uropathy (urinary tract conditions that can cause urine to flow abnormally), hypoxemia (low level of oxygen in the blood). A review of the clinical record failed to reveal and advance directive or documentation that Resident R19 was given the opportunity to formulate an Advanced Directive. (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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the clinical record indicated Resident R25 was readmitted to the facility on [DATE], with diagnoses that include cerebral infarction (serious condition that occurs when blood flow to the brain is blocked, resulting in brain tissue death), GERD, depression, schizophrenia (affects a person's ability to think, feel, and behave clearly). A review of the clinical record failed to reveal and advance directive or documentation that Resident R25 was given the opportunity to formulate an Advanced Directive. A review of the clinical record indicated Resident R27 was readmitted to the facility on [DATE], with diagnoses that include Parkinson's (affects muscles making it difficult to walk), depression, high blood pressure, diabetes (high blood sugar). A review of the clinical record failed to reveal and advance directive or documentation that Resident R27 was given the opportunity to formulate an Advanced Directive. A review of the clinical record indicated Resident R30 was admitted to the facility on [DATE], with diagnoses that include chronic kidney disease (disease of kidneys that leads to kidney failure), high blood pressure, cerebrovascular disease (affects blood vessels of the brain and cerebral circulation), cardiomegaly (enlarged heart). A review of the clinical record failed to reveal and advance directive or documentation that Resident R30 was given the opportunity to formulate an Advanced Directive. A review of the clinical record indicated Resident R46 was admitted to the facility on [DATE], with diagnoses that include high blood pressure, diabetes, pulmonary hypertension (affects arteries in lungs and heart), arthritis (swelling and tenderness in one or more joints). A review of the clinical record failed to reveal and advance directive or documentation that Resident R46 was given the opportunity to formulate an Advanced Directive. A review of the clinical record indicated Resident R51 was admitted to the facility on [DATE], with diagnoses that include morbid obesity (severely overweight), high blood pressure, convulsions (uncontrolled jerking, loss of consciousness, blank stares), neuromyelitis optica (autoimmune disease that attacks the optic nerve making it difficult to see) . A review of the clinical record failed to reveal and advance directive or documentation that Resident R51 was given the opportunity to formulate an Advanced Directive. A review of the clinical record indicated Resident R52 was admitted to the facility on [DATE], with diagnoses that include high blood pressure, diabetes, atrial fibrillation (irregular, often rapid heart rate), dementia. A review of the clinical record failed to reveal and advance directive or documentation that Resident R52 was given the opportunity to formulate an Advanced Directive. A review of the clinical record indicated Resident R59 was admitted to the facility on [DATE], with diagnoses that include diabetes, depression, transient ischemic attack, hyperlipidemia (high cholesterol). (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the clinical record failed to reveal and advance directive or documentation that Resident R59 was given the opportunity to formulate an Advanced Directive. A review of the clinical record indicated Resident R60 was admitted to the facility on [DATE], with diagnoses that include high blood pressure, diabetes, Alzheimer's (progressive disease that destroys memory and other important mental functions), insomnia (problem falling or staying asleep). A review of the clinical record failed to reveal and advance directive or documentation that Resident R60 was given the opportunity to formulate an Advanced Directive. A review of the clinical record indicated Resident R64 was readmitted to the facility on [DATE], with diagnoses that include diabetes, alzheimer's, dysphagia (difficulty swallowing), hypokalemia (low potassium level). A review of the clinical record failed to reveal and advance directive or documentation that Resident R64 was given the opportunity to formulate an Advanced Directive. A review of the clinical record indicated Resident R86 was admitted to the facility on [DATE], with diagnoses that include high blood pressure, atrial fibrillation, heart failure (heart doesn't pump blood as well as it should), pulmonary hypertension. A review of the clinical record failed to reveal and advance directive or documentation that Resident R86 was given the opportunity to formulate an Advanced Directive. A review of the clinical record indicated Resident R87 was admitted to the facility on [DATE], with diagnoses that include vascular dementia (causes memory loss), hypothyroidism (thyroid doesn't produce enough thyroid hormone), depression, hearing loss. A review of the clinical record failed to reveal and advance directive or documentation that Resident R87 was given the opportunity to formulate an Advanced Directive. During an interview on 10/25/24 at 9:05 a.m. the Social Worker and the Assistant Director of Nursing (ADON) confirmed that the clinical record did not include documentation that Resident R5, R19, R25, R27 R30, R46, R51, R52, R59, R60, R64, R86, R87 were not afforded the opportunity to formulate Advance Directives. 28 Pa. Code: 211.15(f) Clinical records. 28 Pa. Code: 211.12(d)(1)(3)(5) Nursing services.

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F 0623 Level of Harm - Potential for minimal harm Residents Affected - Many	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. 50158 Based on a review of facility documents, information from the State Ombudsman Office and staff interviews it was determined that the facility failed to notify the State Ombudsman Office of resident transfers and discharges for past year, 10/2023 through 10/2024, as required. Findings include: A request to review facility documents on 10/23/24, of the facility's compliance in notifying the State Ombudsman Office revealed that the facility failed to provide documented evidence of notifying the State Ombudsman Office of resident transfers and discharges for the time period of 10/23/23 through 10/23/24. A review of information on 8/1/24, provided by the State Ombudsman Office revealed that the facility failed to notify the State Ombudsman Office of transfers and discharges as required since 10/2021. During an interview on 10/23/24, at 10:21 a.m. the Nursing Home Administrator confirmed that the facility failed to report resident transfers and discharges to the State Ombudsman Office for a year period from 10/23/23 through 10/23/24, as required. PA Code: 201.29(f)(g) Resident rights.

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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** 43725 Based on review of facility policy, clinical records, and staff interviews, it was determined that the facility failed to notify physicians of increased and decreased Capillary Blood Glucose (CBG) levels and failed to assess residents for hyperglycemia (high blood glucose) and hypoglycemia (low blood glucose), for two of nine residents reviewed (Residents R27, and R46). Findings include: The Centers for Disease Control defines diabetes as: Diabetes Mellitus is a chronic (long-lasting) health condition that affects how your body turns food into energy. Most of the food you eat is broken down into sugar (also called glucose) and released into your bloodstream. When your blood sugar goes up, it signals your pancreas to release insulin. Insulin acts like a key to let the blood sugar into your body's cells for use as energy. If you have diabetes, your body either doesn't make enough insulin or can't use the insulin it makes as well as it should. When there isn't enough insulin or cells stop responding to insulin, too much blood sugar stays in your bloodstream. Over time, that can cause serious health problems, such as heart disease, vision loss, and kidney disease. Hypoglycemia is a condition that occurs when blood glucose is lower than normal, usually below 70 milligrams per deciliter (mg/dl). If left untreated, hypoglycemia may lead to weakness, confusion, unconsciousness, arrhythmias and even death. People with Diabetes Mellitus may be prescribed injectable insulin to assist in maintaining acceptable levels of CBG's. Hyperglycemia, or high blood glucose, occurs when there is too much sugar in the blood. This happens when your body has too little insulin. Hyperglycemia is blood glucose greater than 125 mg/dL while fasting (not eating for at least eight hours, or a blood glucose greater than 180 mg/dL one to two hours after eating. If you have hyperglycemia and it ' s untreated for long periods of time, you can damage your nerves, blood vessels, tissues and organs. Damage to blood vessels can increase your risk of heart attack and stroke, and nerve damage may also lead to eye damage, kidney damage and non-healing wounds. Review of the facility policy for diabetes reviewed 9/27/23 and 3/27/24, indicated the facility will recognize, assist, and document the treatment of complication commonly associated with diabetes. Step #1 indicated to obtain physician orders for fingerstick blood sugar testing including parameters for intervention. Documentation should reflect the carefully assessed diabetic resident and include level of consciousness, assessment, results of fingerstick blood monitoring, interventions to stabilize blood glucose levels\, and notification to physician of unstable and/or significant variances from base line per physician order. Review of the facility policy Management of Hypoglycemic Reaction reviewed 9/27/23 and 3/27/24, indicated if resident's blood glucose results are less than 70 mg/dl, regardless of symptoms are present, give eight ounces (oz) of orange juice, one tube of glucose gel, prepackaged cookies or other sweetened snack. Recheck blood glucose after 15 minutes. Notify physician as ordered or indicated. Review of the facility policy for change in resident's condition reviewed 9/27/23 and 3/27/24, indicated licensed professional nurses are responsible to provide timely and complete communication to physicians when there is a change in a residents' condition. Document assessment data, attempted or actual correspondence with physician, and physician's response in the medical record. (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 the facility policy Nursing Documentation reviewed 9/27/23 and 3/27/24, indicated to provide an accurate method for demonstrating that care had been provided which reflects current standards or practice, meets resident needs and reflects compliance with state, federal, and provider requirements. Changes in residents' condition or significant resident care issues must be noted and charted until the resident's condition is stabilized ot the situation is resolved. Review of the clinical record indicated Resident R27 was readmitted to the facility on [DATE], with diagnoses that included Parkinson's disease (chronic and progressive movement disorder that initially causes tremor in one hand, stiffness or slowing of movement), depression, and high blood pressure. Review of Resident R27' s Minimum Data Set (MDS - a mandated assessment of a resident's abilities and care needs) dated 10/17/24, indicated the diagnoses remain current. Review of a physician's order indicated for fingerstick blood monitoring results less than 70: implement hypoglycemic protocol. Review of the clinical record electronic Medication Administration Record (eMAR) revealed that the resident's CBG's were as follows: On 7/21/24, at 4:41 p.m. the CBG was noted to be 43. Review of the care plan dated 3/21/23, indicated the following interventions: -Observe for hypo/hyperglycemia -Perform Accu-Checks as ordered and document -Administer insulin as ordered -Notify MD (doctor) as needed is signs/symptoms of hyper/hypoglycemia occur Review of Resident's eMAR and clinical progress notes indicated the resident was not assessed for hypoglycemia, the blood glucose was not monitored for effectiveness of treatment, staff failed to follow interventions of the care plan, and the physician was not notified of abnormal results on the above listed dates. Review of a clinical record indicated Resident R46 was admitted to the facility on [DATE], with diagnoses that included diabetes, depression, and anxiety. Review of the MDS dated [DATE], indicated the diagnoses remain current. Review of physician's orders indicated Accuchecks three times a day before meals with Humalog (a fast-acting insulin that starts to work about 15 minutes after injection, peaks in about 1 hour, and keeps working for 2 to 4 hours) sliding scale coverage. If fingerstick blood monitoring results are greater than 400, give 15 units of insulin. Review of Resident R46's eMAR revealed that the resident's CBG's were as follows: (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/23/23, at 5:17 p.m. the CBG was noted to be 406. On 11/29/23, at 4:01 p.m. the CBG was noted to be 490. On 12/4/23, at 5:40 p.m. the CBG was noted to be 452. On 12/28/23, at 4:38 p.m. the CBG was noted to be 419. On 12/29/23, at 5:14 p.m. the CBG was noted to be 410. On 1/10/24, at 4:33 p.m. the CBG was noted to be 463. On 1/13/24, at 5:36 a.m. the CBG was noted to be 473. On 1/15/24, at 5:00 p.m. the CBG was noted to be 425. On 1/19/24, at 6:00 a.m. the CBG was noted to be 57. On 1/31/24, at 5:05 p.m. the CBG was noted to be 510. On 2/12/24, at 5:18 p.m. the CBG was noted to be 442. On 3/2/24, at 11:46 a.m. the CBG was noted to be 524. On 4/4/24, at 5:20 p.m. the CBG was noted to be 405. On 4/8/24, at 5:49 a.m. the CBG was noted to be 451. On 4/11/24, at 11:54 a.m. the CBG was noted to be 442. On 4/13/24, at 5:42 p.m. the CBG was noted to be 475. On 5/4/24, at 5:57 a.m. the CBG was noted to be 411. On 5/6/24, at 4:53 p.m. the CBG was noted to be 417. On 5/7/24, at 4:49 p.m. the CBG was noted to be 423. On 5/9/24, at 3:58 p.m. the CBG was noted to be 418. On 5/12/24, at 4:39 p.m. the CBG was noted to be 422. On 5/13/24, at 4:03 p.m. the CBG was noted to be 406. On 5/30/24, at 6:44 p.m. the CBG was noted to be 438. On 6/18/24, at 4:12 p.m. the CBG was noted to be 456. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/1/24, at 8:01 p.m. the CBG was noted to be 445. On 7/8/24, at 4:53 p.m. the CBG was noted to be 417. On 7/25/24, at 5:24 p.m. the CBG was noted to be 436. A review of Resident R46's care plan dated 11/20/23, indicated the following interventions: -Accuchecks as ordered, and document -Observe for s/s of hypo/hyperglycemia -Administer medications as ordered and monitor for side effects and effectiveness Review of Resident R46's eMAR and clinical progress notes indicated the resident was not assessed for hyper-/hypoglycemia, failed to follow interventions of the care plan, blood sugar was not rechecked, and the physician was not notified of abnormal results. During an interview on 10/24/24, at 10:35 a.m. Registered Nurse (RN) Employee E2 stated for blood glucose results under 70, they would give juice and/or snacks, hold insulin, and recheck the blood glucose in 15 minutes. They would check the ordered parameters to find out when to call the doctor. If blood glucose was greater than 400, they would give the ordered dose of insulin, call the doctor, and recheck the blood glucose according to doctors orders. They would document in the Nurse's Notes. During an interview on 10/24/24, at 10:37 a.m. Licensed Practical Nurse (LPN) Employee E5 stated if the blood glucose was under 70, they would give a snack or juice. If the blood glucose was greater than 400, they would give the ordered insulin, call the doctor, and recheck the blood glucose in 15-30 minutes. They would document in the Nurse's Notes. During an interview on 10/24/24, at 10:42 a.m. LPN Employee E3 stated if the blood glucose was less than 70, they would give juice or snacks. If blood glucose was over 400, they call the doctor and go from there according to any orders received. They would document in Nurse's Notes. During an interview on 10/24/24, at 10:45 a.m. RN Employee E6 stated for blood glucose less than 70, they would start hypoglycemic protocol, call the doctor, follow any orders received, and recheck the blood glucose in 30-60 minutes. For blood glucose greater than 400, they would check the ordered parameter, give the ordered dose of insulin, and call the doctor. They would monitor the resident, and recheck the blood glucose in 15, 30, and 60 minutes. They would document in the Nurse's Notes During an interview on 10/24/24, at 10:50 a.m. LPN Employee E7 stated for blood sugars less than 70, they would follow the facility's hypoglycemic protocol. If the blood glucose was greater than 400, they would call the doctor. During an interview on 10/24/24, at 10:54 a.m. RN Employee E8 stated they would check the resident's ordered parameters first. If the blood glucose was less than 70, they would give juice or snacks. If the blood glucose was greater that 400, they would call the doctor, monitor the resident, and recheck the blood glucose in 15-30 minutes. They would document in the Nurse's Notes. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/25/24, at 9:05 a.m. the Director of Nursing confirmed the facility failed to notify the doctor of a change in condition, and failed to document an assessment or interventions used related to blood glucose for Residents R27, and R46. 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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50158 Based on review of facility policies, clinical records, and staff interview, it was determined that the facility failed to provide adequate supervision to prevent falls for one of four residents (Resident R51). Findings include: Review of the facility policy, ADL (Activities of Daily Living) Documentation dated 3/27/24, indicated the nursing assistant will review the CNA Flowsheet which includes mobility and transfers needs. At the end of the shift the Nursing Assistant will document bed mobility and transfers. ADL documentation includes the level of resident's ability to perform tasks and the amount of staff assistance needed. Before change over, the Unit Manager, or designee will review each resident's ADL information and revise as necessary. Review of the American Congress of Rehabilitation Medicine - Caregiver Guide and Instructions for Safe Bed Mobility published 4/28/17, indicated bed mobility refers to activities such as scooting in bed, rolling, side-lying to sitting, and sitting to lying down. Resident R51 was admitted to the facility on [DATE]. Review of Resident 51's Minimum Data Set (MDS - periodic assessment of resident care needs) dated 9/5/24, included diagnoses of morbid obesity (chronic disease in which a person has a body mass index (BMI) of 40 or higher or a BMI of 35 or higher and is experiencing obesity-related health conditions), neuromyelitis optica (NMO) autoimmune disease of the central nervous system (can cause blindness in one or both eyes, weakness or paralysis in the legs or arms, and painful spasms) and paraplegia (paralysis that occurs in the lower half of the body). Review of Resident R51's MDS dated [DATE] assessments, Section G - Functional Status, Questions G0110A, ADL Assistance for Bed Mobility, indicated that Resident R51 required extensive assistance of two or more staff members. Review of Resident R51's plan of care for Impaired Mobility quarterly review dated 9/11/24, indicated extensive to total assistance for ADL tasks. Review of a physician order dated and 9/26/24, indicated Resident R51 required an assist of two staff members for mobility. Review of the September and the October 2024 Task CNA (nurse aide) Flowsheet for the 3:00 p.m. to 11:00 p.m. shift indicates Resident R51 requires assistance of two for mobility. Review of the CNA Employee E9 3:00 p.m. to 11:00 p.m. Assignment Sheet for 10/1/24 indicated Resident R51 is an assist of two. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a progress note dated 10/1/24, at 8:08 p.m. indicated, CNA Employee E9 reported resident had fallen out of bed during care. CNA Employee E9 stated residents' legs slid off the right side of the bed. Per resident baseline she has no control on movement of bilateral lower extremities Resident was lowered to a laying position on the floor by four staff members a Hoyer lift was used with assistance of four staff to return resident to bed. During this time resident had complaints of intermittent pain to her head and left shoulder. MD (doctor of medicine) and resident sister notified. Resident was sent to the hospital at 6:00 pm. Review of emergency room documentation dated 10/1/24, indicated Resident R51 was treated for a fall and closed head injury. Resident R51 imaging did not reveal any major injury related to the fall as reflected in the facility progress notes. Resident R51 returned to the facility at 9:00 p.m. the same date of the fall. Review of facility submitted information dated 10/2/24, indicated, On 10/1/2024 at approximately 5:15 p.m. Resident R51 is non-ambulatory and transfers with a Hoyer lift and assist of 2, she is an assist of 2 for mobility. CNA Employee E9 went in to provide care turning the resident on her side positioning her in the center of the bed. CNA Employee E9 went to the bathroom to get the washcloths and when she was returning Resident R51 grabbed the siderail pulling herself over and her legs went off the side of the bed, pulling her to the floor to a sitting position before CNA Employee E9 could reach her. Resident R51 is alert and oriented x3. Review of an employee statement written by CNA Employee E9 dated 10/1/24, indicated, She [Resident 51 R51] was on her side facing the door turned away from me. I had went to wet more washcloths and she was positioned in the middle of the bed. When I came back from getting the wet washcloths she was holding onto the railing and was pulling herself over more and her bottom half starred rolling over the side of the bed before I could get her legs to stop it from happening. Review of a facility submitted Report Form for Investigation of Alleged Abuse, Neglect, Misappropriation of Property dated 10/2/24, included the information, Staff member did not follow MD orders for two-person bed mobility. The CNA Employee E9 was educated on the importance of following MD orders for bed mobility and abuse and Neglect. Review of the facility Employee Discipline Warning Notice dated 10/2/24, the CNA Employee E9 received a written warning for policy breach and not following professional standards. Additional documentation included The employee failed to follow physician's orders for two person assist for bed mobility. The employee must follow MD orders. Any further infraction of this nature will result in further disciplinary action up to and including termination. This document was signed by the CNA Employee E9 and the Assistant Director of Nursing. During an interview on 10/22/24 at approximately 1:45 p.m., Resident R51 stated CNA Employee E9 rolled her onto her side while providing her care. CNA Employee E9 then left the bedside and went to get more supplies leaving the resident unattended. Resident R51 was holding onto the railing to keep herself on her side and her legs slid out of the bed and she fell . Resident R51 reported that two staff members provide her care and confirmed that only CNA Employee E9 was providing care when she fell . (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395823	A. Building B. Wing	10/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Townview Health and Rehabilitation Center	300 Barr Street Canonsburg, PA 15317

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During staff interviews on 10/24/24 Employees CNA Employee E1, RN Employee E2, LPN Employee E3, and CNA employee E4 verbalized the facility policy for ADL care and the location in the record for resident mobility. This included receiving the information at the start of each shift. During an interview on 10/25/24 at approximately 9:55 a.m. the NHA confirmed Resident R51 required assistance of two for bed mobility and the facility failed to provide adequate supervision to prevent falls for one of four residents (Resident R51). 28 Pa. Code: 201.14 (a) Responsibility of licensee. 28 Pa. Code: 201.18 (b)(e)(1) Management. 28 Pa. Code: 201.20(b)(1) Staff development. 28 Pa. Code: 201.29(a) Resident rights. 28 Pa. Code: 211.10(c)(d) Resident care policies. 28 Pa Code: 211.12(d)(1)(2)(5) Nursing services.