

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395826	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/12/2024
NAME OF PROVIDER OR SUPPLIER Highland Hills Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 1105 Perry Highway Pittsburgh, PA 15237	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0565</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to organize and participate in resident/family groups in the facility.</p> <p>46336</p> <p>Based on review of facility policy, facility documentation, and resident and staff interviews, it was determined that the facility failed to address repetitive grievances/concerns voiced during resident council meetings and individual grievances for four of six months (August 2024, September 2024, October 2024, and November 2024).</p> <p>Findings include:</p> <p>Review of the facility policy Grievances/Complaints, Filing last reviewed on 3/5/24, and again on 11/1/24, indicated residents have the right to file grievances, either orally or in writing, to the facility staff. The administrator and staff will make prompt efforts to resolve grievances to the satisfaction of the resident.</p> <p>Review of facility provided grievance logs August 2024, through November 2024, indicated the following concerns:</p> <ul style="list-style-type: none"> -Resident R9's family filed a grievance dated 8/5/24, that the Arcadia unit's appearance was inadequate, along with the cleanliness. -Resident R67 filed a grievance on 9/3/24, regarding availability of linens and washcloths. -Resident R43's family filed a grievance on 9/4/24, that the Arcadia unit floors needed cleaned. -Resident Council filed a grievance on 9/18/24, that they were informed by staff of only being permitted one transfer in or out of bed per shift. -Resident R141 filed a grievance on 10/24/24, requesting a policy for microwaving foods. <p>Review of Resident Council meeting minutes for the meeting on 9/18/24, indicated the following concerns:</p> <ul style="list-style-type: none"> -Nurse Aides (NA) do not check on them and seeing if they need anything. Some residents feel like they are a big inconvenience to the NA's. -Late meal trays. Trays arrive timely, but staff are bickering and pass them late. <p>(continued on next page)</p>		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0565</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Staff are wearing ear buds and on their cell phones</p> <p>-Staff told the residents that the NA's are not to do anything until the trays are picked up.</p> <p>Review of Resident Council meeting minutes for the meeting on 10/24/24, indicated the following concerns:</p> <p>-Residents - there is no one available for help. It's hard to get ice/water when no one is around.</p> <p>-Staff issues that were brought up included:</p> <p>-Call bell wait times.</p> <p>-Can food be microwaved?</p> <p>-Ear buds and cell phone use by staff is out of control.</p> <p>-When there are two staff in a resident room, they talk over the resident and not to the resident.</p> <p>-Are NA's only allowed to work with their assigned residents or can others assist the resident?</p> <p>-Residents have waited a long time for water.</p> <p>Review of the Resident Council meeting minutes for the meeting on 11/21/24, indicated the following concerns:</p> <p>-A resident stated there were not enough washcloths/towel for care twice in one week.</p> <p>-Staff wearing ear buds and on their cell phones.</p> <p>-A resident stated they need help to get out of bed and the NA's are not helping them.</p> <p>-A resident stated the NA's told them they weren't permitted to do anything until trays are picked up.</p> <p>-Some residents feel as if they are an inconvenience to the staff. Are staff supposed to check on the residents?</p> <p>During a Resident Group interview on 12/9/24, at 11:00 a.m. the groups consensus was:</p> <p>-Things we've asked for have not been improved. Length of time to get a call bell answered, missing clothing, not enough clean laundry, especially towels and wash cloths. The aides are ripping the towels into washcloths to provide care.</p> <p>-Once in bed you have to stay there, one lift in or out of bed per shift, according to the NA's.</p> <p>-Ear pods - you don't know if they're talking to you or somebody else.</p> <p>(continued on next page)</p>

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<p>F 0565</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-If you ask for things, they act like it's a burden to them.</p> <p>-If a NA is not your assignment, they walk right by without helping.</p> <p>-The food carts come and aren't passed timely because staff are bickering about assignments.</p> <p>-There is no way to heat your meals up. There is not a microwave available.</p> <p>-The NA's don't have enough washcloths to take care of us.</p> <p>Interview on 12/11/24, at 2:35 p.m. the Nursing Home Administrator confirmed that the facility failed to address repetitive grievances/concerns voiced during resident council meetings and individual grievances for four of six months (August 2024, September 2024, October 2024, and November 2024).</p> <p>28 Pa Code: 201.14(a) Responsibility of licensee.</p> <p>28. Pa Code 201.18 (e)(4) Management.</p>

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<p>F 0582</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46336</p> <p>Based on the Code of Federal Regulations (CFR), clinical records, facility documents, and staff interviews, it was determined that the facility failed to provide timely notice of the Notice of Medicare Non-Coverage (NOMNC) for one of three sampled resident records (Closed Resident Record CR1).</p> <p>Findings include:</p> <p>Review of the CFR indicated at GUIDANCE S483.10(g)(17)-(18), the NOMNC, Form CMS-10123, is given by the facility to all Medicare beneficiaries at least two days before the end of a Medicare covered Part A stay or when all of Part B therapies are ending. The NOMNC informs the beneficiaries of the right to an expedited review by a Quality Improvement Organization.</p> <p>Review of Closed Resident Record CR1's admission record indicated they were admitted on [DATE], with diagnoses that included breast cancer, atrial fibrillation (irregular heart rhythm), and heart failure (heart doesn't pump blood as well as it should).</p> <p>Review of Closed Resident Record CR1's Minimum Data Set (MDS - a periodic assessment of care needs) dated 11/8/24, indicated the diagnoses remained current.</p> <p>Review of Closed Resident Record CR1's NOMNC indicated the effective date coverage of skilled services will end as 11/18/24.</p> <p>Review of the same NOMNC indicated the resident discharged to home prior to the NOMNC being presented on 11/18/24, and the facility would mail it to the home address.</p> <p>During an interview on 12/11/24, at 1:00 p.m. the Nursing Home Administrator confirmed that the facility failed to provide timely notice of the NOMNC for one of three sampled resident records (Closed Resident Record CR1).</p> <p>28 Pa. Code 201.14(a) Responsibility of Licensee.</p> <p>28 Pa. Code 201.18(e)(1) Management.</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>46336</p> <p>Based on review of facility policy, observations and staff interviews, it was determined that the facility failed to provide a clean, safe, comfortable, and homelike environment for seven of 15 resident wheelchairs (Residents R4, R5, R9, R49, R69, R89, and R93), failed to maintain structure of wall surface in two area (Resident R144's room and Arcadia Unit Dining Room), failed to maintain an adequate supply of washcloths readily available for staff use on two of four units (LTC and TCC units), and failed to ensure the privacy curtains were clean and sanitary for two of ten resident rooms (Residents R81 and R124).</p> <p>Findings include:</p> <p>Review of the facility policy Cleaning and Disinfecting Residents' Rooms dated 11/1/24, indicated housekeeping surfaces (e.g. floors, tabletops, and wheelchairs) will be cleaned on a regular basis, when spills occur, and when these surfaces are visibly soiled.</p> <p>Review of the facility policy Quality of Life - Homelike Environment dated 11/1/24, indicated residents are provided with a safe, clean, comfortable, and homelike environment. Homelike setting includes cleanliness and order.</p> <p>Observations of the Arcadia Unit (Memory care unit) on 12/8/24, at 9:25 a.m. indicated the following appearance of residents' wheelchairs:</p> <ul style="list-style-type: none"> -Resident R4 was seated at the breakfast table. The frame, wheels, brake locks and sides of the chair were corroded with dried food substances and corroded in grime. -Resident R5 was seated at the breakfast table. The frame, wheels, and seat of the wheelchair were corroded with dried substance and corroded in grime. -Resident R9 was seated at the breakfast table. The frame, wheels, brakes, and seat of the wheelchair were corroded with dried substance and corroded in grime. -Resident R49 was seated at the breakfast table. The frame, wheels, brakes, and seat of the wheelchair were corroded with dried substance and corroded in grime. -Resident R69 was seated at the breakfast table. The frame, wheels, brakes, foot positioner attachment, and seat of the wheelchair were corroded with dried substance and corroded in grime. -Resident R89 was seated at the breakfast table. The frame, wheels, brake locks and sides of the chair were corroded with dried food substances and corroded in grime. -Resident R93 was seated at the breakfast table. The frame, wheels, seat, and sides of the chair were corroded with dried food substances and corroded in grime. <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Observation on 12/8/24, at 9:30 a.m. indicated an almost continuous gouge in the wall of the Arcadia Dining room's perimeter.</p> <p>Observation on 12/8/24, at 9:35 a.m. Resident R144's room had a continuous gouge across the side wall to the left of the doorway entrance.</p> <p>Interview on 12/8/24, at 9:36 a.m., Registered Nurse (RN) Employee E4 confirmed Resident R144's room had a continuous gouge across the side wall to the left of the doorway entrance.</p> <p>Interview on 12/08/24, at 9:31 a.m., Registered Nurse (RN) Supervisor Employee E3 confirmed the appearance of dried grime on the above listed residents wheelchairs and the gouge surrounding the dining room walls.</p> <p>Observation on 12/10/24, at 9:10 a.m., an unidentified Nurse Aide (NA) was observed wheeling a resident to the shower room. The NA stated, Wait here, I'll try to find a washcloth for your shower.</p> <p>Observation on 12/10/24, at 9:21 a.m., indicated no washcloths available on either laundry cart for LTC or TCC units.</p> <p>Interview on 12/10/24, at 9:23 a.m., Licensed Practical Nurse (LPN) Employee E5 indicated The laundry guy, the other day said they are low on linen. LPN Employee E5 indicated she asked if the laundry was short on staff and the laundry guy stated no, nobody called off we just don't have enough.</p> <p>Observation of the facility laundry room on 12/10/24, at 9:29 a.m. indicated no clean washcloths available and the emergency linen storage area was full of all linens with the exception of washcloths.</p> <p>Interview on 12/10/24, at 9:30 a.m. District Manager of Housekeeping (DMH) Employee E6, indicated an order was placed last week. The towels have arrived, but the washcloths are on back order with expected delivery not until 12/30/24. DMH Employee E6 further explained the facility was tearing towels in half to facilitate more washcloths being available.</p> <p>Observation on 12/8/24, at 9:38 a.m., the room dividing curtain facing Resident R81 was visibly stained with numerous brown patches.</p> <p>Interview on 12/8/24, at 9:41 a.m., RN Employee E17 confirmed the room dividing curtain facing Resident R81 was visibly stained with numerous brown patches and stated, I will let laundry know.</p> <p>Observation on 12/8/24, at 9:07 a.m., the room dividing curtain facing Resident R124 was visibly stained with numerous brown patches.</p> <p>Interview on 12/8/24, at 9:14 a.m., RN Employee E3 confirmed the room dividing curtain facing Resident R124 was visibly stained with numerous brown patches and stated, we will get that.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Interview on 12/10/24, at 3:00 p.m. the Nursing Home Administrator confirmed that the facility failed to provide a clean, safe, comfortable, and homelike environment for seven of 15 resident wheelchairs (Residents R4, R5, R9, R49, R69, R89, and R93), failed to maintain structure of wall surface in two area (Resident R144's room and Arcadia Unit Dining Room), failed to maintain and adequate supply of washcloths readily available for staff use on two of four units (LTC and TCC units), and failed to ensure the privacy curtains were clean and sanitary for two of ten resident rooms (Residents R81 and R124).</p> <p>28 Pa. Code 201.14(a) Responsibility of Licensee.</p> <p>28 Pa. Code 201.18(e)(1) Management.</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48546</p> <p>Based on review of facility policy, clinical record review, and staff interviews, it was determined that the facility failed to ensure that residents were free from neglect for two of six residents reviewed (Residents R67 and R106).</p> <p>Findings include:</p> <p>Review of facility policy Abuse Prohibition dated 3/5/24, indicated neglect is defined as the failure of the Center, its employees, or service providers to provide goods and services to a patient that are necessary to avoid physical harm, pain, mental anguish, or emotional distress.</p> <p>Review of facility policy Safe Resident Handling/Transfer Equipment dated 3/5/24, indicated safe resident handling involves the use of assistive devices to ensure that patients can be transferred safely and that care providers avoid performing high risk patient handling tasks. The Total Lift is used for those patients who are dependent non-weight bearing or have inconsistent weight bearing.</p> <p>Review of the clinical record indicated Resident R67 was admitted to the facility on [DATE].</p> <p>Review of Resident R67's Minimum Data Set (MDS - a periodic assessment of care needs) dated 9/13/24, indicated diagnoses of high blood pressure, hyperlipidemia (high levels of fat in the blood), and anemia (too little iron in the blood).</p> <p>Review of Resident R67's care plan dated 7/28/23, indicated to transfer with mechanical lift with blue sling.</p> <p>Review of Resident R67's Lift Transfer Evaluation dated 9/13/24, indicated Resident R67 required a total lift full body sling.</p> <p>Review of Resident R67's Kardex (a snapshot of resident care needs) dated 10/11/24, indicated to transfer with mechanical lift with blue sling.</p> <p>Review of facility submitted documentation dated 10/11/24, stated, Resident R67 was in her bed getting ready to get her shower. Her Nurse Aide (NA) came into her room to get her out of bed for her shower and the resident stated, I don't use the Hoyer (mechanical lift) anymore, I have been working with therapy for two months and I can stand. So NA proceeded to set everything up for her to stand from her bed to the walker and into the shower chair. She started to stand up and got close to the edge of the bed and began to slip. NA assisted her to the floor and then called for the nurse to come in to perform a head to toe assessment. Resident was ordered a mechanical lift for transfers. Investigation initiated for neglect to read Kardex and utilize mechanical life for transfer.</p> <p>Review of a nursing progress note dated 10/11/24, stated, When resident was being transferred from bed into shower chair, resident stated her legs were starting to give out. NA Employee E2 lowered her to the floor onto her buttocks. No injuries noted. No complain of discomfort. No change in range of motion.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of a witness statement dated 10/11/24 indicated Resident R67 stated, I have been working with therapy for two months now and have not been using the Hoyer. So when I got my shower the last time, I went from my bed to the walker to the shower chair and everything was fine. I came back and everything was fine. Today, NA Employee E2 came in and she went and got someone to help. I told her I don't use the Hoyer anymore, so I told her that I had to position my feet in a certain way, but I started to stand and my butt was on the edge of the bed. Someone came in and the process started, but I couldn't feel my feet. I was on the edge of the bed and I was going to transfer to the walker and it didn't work. My feet are dead from the ankles down. I didn't fall, I sort of stepped backwards. NA Employee E2 tried to hold me up, but we needed the other girl that helped her. So I sat on the floor and she went and got the nurse and another staff member and they all helped get me back on the bed. Then I was ok. Nothing hurts, everything is ok.</p> <p>Review of a witness statement dated 10/11/24, indicated NA Employee E2 stated, I was getting her [Resident R67] out of bed for her shower and she stated that she does not use the Hoyer lift anymore because she's been working with therapy. So we were going from her bed to her shower chair, she stood up and started to slowly sit down. I grabbed her to help her so she didn't get hurt. She sat on the ground on her buttocks and I yelled for the nurse to come assess her. The nurse did her assessment and then another aide and I stood her back up to get back into bed.</p> <p>During an interview on 12/12/24, at 9:52 a.m. the Director of Nursing (DON) stated, Resident R67 had been working on transfers with therapy and was transferring without a mechanical lift, but the transfer order had not been updated. Resident R67 should have been transferred using the lift.</p> <p>During an interview on 12/12/24, at 9:52 a.m. the DON confirmed that the facility failed to ensure Resident R67 was free from neglect.</p> <p>Review of facility policy Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating dated 11/1/24, indicated all reports of resident abuse (including injuries of unknown origin), neglect, exploitation, or theft/misappropriation of resident property are reported to local, state and federal agencies (as required by current regulations) and thoroughly investigated by facility management. Findings of all investigations are documented and reported.</p> <p>Review of facility policy Wound Care dated 11/1/24, indicated guidelines for the care of wounds to promote healing. Verify that there is a physician for wound care procedure. The following information should be recorded in the resident's medical record: If the resident refused the treatment and the reason(s) why; and the signature and title of the person recording the data.</p> <p>Review of the clinical record indicated Resident R106 was admitted to the facility 10/31/24.</p> <p>Review of Resident R106's Minimum Data Set (MDS - a periodic assessment of care needs) dated 11/7/24, indicated diagnoses of displaced bimalleolar fracture (injury to both the inner side and outer side of the ankle) of left lower leg, alcoholic cirrhosis of liver, and acute kidney failure.</p> <p>Review of physician order dated 11/27/24, indicated for LLE (left lower extremity) Pin care. Cleanse with normal saline (water and salt solution), wrap with xeroform (petrolatum-impregnated gauze dressing with bacteriostatic action for light exudating wounds) then gauze every shift for pin care foot LLE.</p> <p>(continued on next page)</p>		

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<p>F 0636</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48546</p> <p>Based on review of the Resident Assessment Instrument User's Manual, clinical records, and staff interview, it was determined that the facility failed to make certain that comprehensive Minimum Data Set assessments were completed in the required time frame for six of ten residents reviewed (Residents R2, R91, R107, R132, R256, and R259).</p> <p>Findings include:</p> <p>Review of the Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual, which provides instructions and guidelines for completing required Minimum Data Set (MDS) assessments (mandated assessments of a resident's abilities and care needs), dated October 2024, indicated that an admission MDS assessment was to be completed no later than 14 calendar days following admission (admitted plus 13 calendar days), and an annual MDS assessment was to be completed no later than the Assessment Reference Date (ARD) plus 14 calendar days.</p> <p>Resident R2 had an ARD of 11/14/24, with a complete by date of 11/28/24. A review on 12/10/24, revealed Resident R2's MDS had not been completed.</p> <p>Resident R91 had an admitted [DATE], with an MDS completion date of 11/20/24. A review on 12/10/24, revealed Resident R91's admission MDS had not been completed.</p> <p>Resident R107 had an ARD of 11/19/24, with a complete by date of 12/3/24. A review on 12/10/24, revealed Resident R107's MDS had not been completed.</p> <p>Resident R132 had an ARD of 11/6/24, with a complete by date of 11/20/24. A review on 12/10/24, revealed Resident R132's MDS had not been completed.</p> <p>Resident R256 had an admitted [DATE], with an MDS completion date of 11/19/24. A review on 12/10/24, revealed Resident R256's admission MDS had not been completed.</p> <p>Resident R259 had an admitted [DATE], with an MDS completion date of 12/5/24. A review on 12/10/24, revealed Resident R259's admission MDS was completed on 12/10/24.</p> <p>During an interview on 12/10/24, at 1:31 p.m. Registered Nurse Assessment Coordinator (RNAC) Employee E1 stated, That is correct. When we switched companies our computer system was down for a week and when we got the new system the RNACs were put in incorrectly, so we were unable to chart. It took two weeks to get us the correct access. We are about three weeks behind on completing the assessments.</p> <p>During an interview on 12/10/24, at 2:01 p.m. the Director of Nursing confirmed that the facility failed to make certain that comprehensive Minimum Data Set assessments were completed within the required time frame for six of ten residents reviewed.</p> <p>28 Pa. Code 211.5(f) Clinical Records.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395826	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/12/2024
NAME OF PROVIDER OR SUPPLIER Highland Hills Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 1105 Perry Highway Pittsburgh, PA 15237	
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<p>F 0638</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Assure that each resident's assessment is updated at least once every 3 months.</p> <p>48546</p> <p>Based on review of the Resident Assessment Instrument User's Manual, clinical records, and staff interview, it was determined that the facility failed to make certain that that quarterly Minimum Data Set assessments were completed within the required time frame for 21 of 38 residents reviewed (Resident R17, R29, R30, R32, R33, R34, R38, R51, R55, R61, R79, R97, R101, R102, R105, R117, R122, R123, R124, R127, and R136).</p> <p>Findings include:</p> <p>Review of the Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual, which provides instructions and guidelines for completing required Minimum Data Set (MDS) assessments (mandated assessments of a resident's abilities and care needs), dated October 2024, indicated that quarterly MDS assessments were to be completed no later than 14 calendar days after the Assessment Reference Date (ARD).</p> <p>Resident R17 had an ARD of 11/5/24, with a complete by date of 11/19/24. A review on 12/10/24, revealed Resident R17's MDS had not been completed.</p> <p>Resident R29 had an ARD of 11/3/24, with a complete by date of 11/17/24. A review on 12/10/24, revealed Resident R29's MDS had not been completed.</p> <p>Resident R30 had an ARD of 11/3/24, with a complete by date of 11/17/24. A review on 12/10/24, revealed Resident R30's MDS had not been completed.</p> <p>Resident R32 had an ARD of 11/4/24, with a complete by date of 11/18/24. A review on 12/10/24, revealed Resident R32's MDS had not been completed.</p> <p>Resident R33 had an ARD of 11/2/24, with a complete by date of 11/16/24. A review on 12/10/24, revealed Resident R33's MDS had not been completed.</p> <p>Resident R34 had an ARD of 11/5/24, with a complete by date of 11/19/24. A review on 12/10/24, revealed Resident R34's MDS had not been completed.</p> <p>Resident R38 had an ARD of 11/6/24, with a complete by date of 11/20/24. A review on 12/10/24, revealed Resident R38's MDS had not been completed.</p> <p>Resident R51 had an ARD of 11/6/24, with a complete by date of 11/20/24. A review on 12/10/24, revealed Resident R51's MDS had not been completed.</p> <p>Resident R55 had an ARD of 11/5/24, with a complete by date of 11/19/24. A review on 12/10/24, revealed Resident R55's MDS had not been completed.</p> <p>Resident R61 had an ARD of 11/6/24, with a complete by date of 11/20/24. A review on 12/10/24, revealed Resident R61's MDS had not been completed.</p> <p>(continued on next page)</p>		

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<p>F 0638</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Resident R79 had an ARD of 11/24/24, with a complete by date of 12/8/24. A review on 12/10/24, revealed Resident R79's MDS had not been completed.</p> <p>Resident R97 had an ARD of 11/25/24, with a complete by date of 12/9/24. A review on 12/10/24, revealed Resident R97's MDS had not been completed.</p> <p>Resident R101 had an ARD of 11/2/24, with a complete by date of 12/5/24. A review on 12/10/24, revealed Resident R101's MDS had not been completed.</p> <p>Resident R102 had an ARD of 11/6/24, with a complete by date of 11/20/24. A review on 12/10/24, revealed Resident R102's MDS had not been completed.</p> <p>Resident R105 had an ARD of 11/22/24, with a complete by date of 12/6/24. A review on 12/10/24, revealed Resident R105's MDS had not been completed.</p> <p>Resident R117 had an ARD of 11/7/24, with a complete by date of 11/21/24. A review on 12/10/24, revealed Resident R117's MDS had not been completed.</p> <p>Resident R122 had an ARD of 11/2/24, with a complete by date of 11/16/24. A review on 12/10/24, revealed Resident R122's MDS had not been completed.</p> <p>Resident R123 had an ARD of 11/3/24, with a complete by date of 11/17/24. A review on 12/10/24, revealed Resident R123's MDS had not been completed.</p> <p>Resident R124 had an ARD of 11/4/24, with a complete by date of 11/18/24. A review on 12/10/24, revealed Resident R124's MDS had not been completed.</p> <p>Resident R127 had an ARD of 11/2/24, with a complete by date of 11/16/24. A review on 12/10/24, revealed Resident R127's MDS had not been completed.</p> <p>Resident R136 had an ARD of 11/23/24, with a complete by date of 12/7/24. A review on 12/10/24, revealed Resident R136's MDS had not been completed.</p> <p>During an interview on 12/10/24, at 1:31 p.m. Registered Nurse Assessment Coordinator (RNAC) Employee E1 stated, That is correct. When we switched companies our computer system was down for a week and when we got the new system the RNACs were put in incorrectly, so we were unable to chart. It took two weeks to get us the correct access. We are about three weeks behind on completing the assessments.</p> <p>During an interview on 12/10/24, at 2:01 p.m. the Director of Nursing confirmed that the facility failed to make certain that quarterly Minimum Data Set assessments were completed within the required time frame for 21 of 38 residents reviewed.</p> <p>28 Pa. Code 211.5(f) Clinical Records.</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>49469</p> <p>Based on review of facility policies, clinical records, and staff interviews, it was determined that the facility failed to develop and implement comprehensive care plans to meet care needs for two of four residents (Resident R139 and R143).</p> <p>Findings include:</p> <p>A review of facility policy Care Plans, Comprehensive Person - Centered dated 3/5/24, last reviewed 11/1/24, indicated a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident.</p> <p>Review of Resident R139's MDS (Minimum Data Set - periodic assessment of resident care needs) dated 10/15/24, indicates reentry to facility on 10/8/24, with the diagnosis of anemia (low iron in the blood) gastroesophageal reflux disease (GERD- stomach acid repeatedly flows back up into the esophagus causing heartburn and other problems) and anxiety. Section K - Swallowing/Nutritional Status, K0520B indicated Resident R139 had a feeding tube.</p> <p>Review of Resident R139's physician orders 11/25/24, indicated enteral feed five times a day bolus. Jevity 1. 5, 360 milliliter (ml) five times a day.</p> <p>Review of Resident R139's December 2024, medication administration record (MAR) indicated bolus feedings given as ordered.</p> <p>Review of Resident R139's care plan failed to include the route of feeding tube administration.</p> <p>Review of clinical record indicated Resident R143 was admitted to facility on 10/15/24.</p> <p>Review of Resident R143's Minimum Data Set (MDS - a periodic assessment of care needs) dated 10/22/24, indicated diagnoses of hemiplegia (one-sided paralysis) and hemiparesis (one-sided weakness) following unspecified cerebrovascular disease affecting left dominant side, chronic obstructive pulmonary disease (progressive lung disease causing obstructive airflow and breathing difficulties), and hydrocephalus (condition characterized by excess fluid build-up in fluid-containing cavities of the brain, which results in developmental, physical, and intellectual impairments). Section K - Swallowing/Nutritional Status, K0520B indicated Resident R143 had a feeding tube.</p> <p>Review of Resident R143's physician order dated 10/15/24, indicated Enteral feed order every shift, Jevity 1. 5 CAL Administer bolus via pump 85 ML (milliliters) per hour x 16 hours.</p> <p>Review of Resident R143's, December 2024, medication administration record (MAR) indicated enteral feedings given as ordered.</p> <p>Review of Resident R143's care plan failed to include a focus, goals, and/or interventions for enteral nutrition support via a feeding tube.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 12/10/24, at 1:10 p.m., Registered Dietician (RD) Employee E27 confirmed that Resident R139's care plan did not include the route of the feeding tube administration, and confirmed that Resident R143 did not have a care plan for enteral nutrition support via a feeding tube, and stated I am updating all of them now.</p> <p>During an interview on 12/12/24, at 2:00 p.m., the Nursing Home Administrator (NHA) and Director of Nursing (DON) confirmed that the facility failed to develop and implement comprehensive care plans to meet care needs for two of four residents (Resident R139 and R143).</p> <p>28 Pa. Code 211.10(c)(d) Resident Care Policies</p> <p>28 Pa. Code 211.12(d)(1)(2)(5) Nursing Services</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46336</p> <p>Based on review of facility policy, clinical records, observation, and interviews with staff, it was determined that the facility failed to make certain that residents were monitored, assessed, and received the necessary services to prevent pressure ulcers/wounds from developing or worsening for three of three residents (Residents R140, R150, and R152).</p> <p>Findings include:</p> <p>Review of the facility policy Pressure Ulcers/Skin Breakdown-Clinical Protocol dated 11/1/24, indicated the nursing staff shall describe and document the following: full assessment of pressure sore including location, stage, length, width and depth, presence of exudate's (fluids released from a wound) or necrotic tissue (death of tissue through disease); pain assessment; resident's mobility status, current treatments, including support surfaces; and all active diagnoses. The staff will examine the skin of a new admission for ulcerations or alterations in skin.</p> <p>Review of the admission record indicated Resident R140 was admitted to the facility on [DATE].</p> <p>Review of Resident R140's Minimum Data Set (MDS - a periodic assessment of care needs) dated 9/20/24, indicated the diagnoses chronic obstructive pulmonary disease (COPD - condition involving constriction of the airways and difficulty or discomfort in breathing), congestive heart failure (chronic condition in which the heart doesn't pump blood as well as it should), and anemia (the blood doesn't have enough healthy red blood cells).</p> <p>Review of Resident R140's Braden Scale for Predicting Pressure Sore Risk dated 9/20/24, indicated a score of 13 - moderate risk.</p> <p>Review of Resident R140's physician order dated 11/29/24, indicated the following: coccyx - apply Vashe (wound solution for moistening and debriding) soaked compress to wound bed for 10-15 minutes and do not rinse; apply collagen AG (wound treatment that contains collagen and silver to help heal wounds) to wound bed; cover with gauze dressing. Change every other day on night shift.</p> <p>Further review of Resident R140's current physician orders indicated pressure redistribution cushion to chair and bed.</p> <p>Review of Resident R140's current care plan indicated air mattress and pressure redistributing device on bed and chair and an intervention of Vicare (preventative cushion that uses air technology) cushion to wheelchair dated 6/4/24.</p> <p>Observation of Resident R140's bed on 12/11/24, at 10:15 a.m. did not have an air mattress on the frame.</p> <p>Observation of Resident R140 in the wheelchair on 12/10/24, at 9:15 a.m. indicated the wheelchair had a regular cushion, not a Vicare as indicated.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 12/11/24, at 9:57 a.m. Director of Rehab Employee E7 indicated Resident R140 was discharged from therapy services on 10/3/24, with a Vicare cushion and further indicated that upon assessment of Resident R140's chair the day prior, on 12/10/24, Resident R140 was not seated on the appropriate cushion of a Vicare and was issued a new one by the therapy department.</p> <p>During an interview on 12/11/24, at 10:40 a.m. Registered Nurse (RN) Employee E8 indicated I don't know what happen to her cushion. Therapy came down and gave her a new Vicare yesterday.</p> <p>Review of the admission record indicated Resident R150 was admitted to the facility on [DATE], with diagnoses of diabetes mellitus, and depression.</p> <p>Review of Resident R150's Braden Scale Assessment (assessment tool used to predict the risk of developing pressure ulcer in patients. Score ranges from 6-23, with lower score signifying a greater risk for developing pressure ulcers. If less than 15, proceed to Care Plan and initiate intervention.) dated 10/21/24, indicated the resident score was 15.0, at risk.</p> <p>Review of Resident R150's Minimum Data Set (MDS - a periodic assessment of care needs) dated 10/28/24, indicated the diagnoses were current. Section M-Skin Conditions M0210. Unhealed pressure ulcers indicated the resident has one pressure ulcers.</p> <p>Review of Resident R150's clinical admission note dated 10/21/24, entered by Registered Nurse Employee E28 indicated presence of open area on right Ischium. There was no documentation of measurements of the wound.</p> <p>Review of the facility's Pressure Sore List dated 12/8/24, indicated Resident R150 was admitted with Right ischial wound a coccyx pressure ulcer on 10/21/24, stage three.</p> <p>Review of the admission record indicated that Resident R152 was admitted to facility 10/29/24.</p> <p>Review of Resident R152's Minimum Data Set (MDS - a periodic assessment of care needs) dated 11/5/24, indicated the diagnoses fracture of spine, spinal stenosis (condition where spinal column narrows and compresses the spinal cord), and chronic pulmonary embolism (condition in which one of the pulmonary arteries in the lungs gets blocked by a blood clot). Section M-Skin Conditions, M0210. Unhealed Pressure ulcers/injuries, indicated that Resident R152 was coded No when asked Does this resident have one or more unhealed pressure ulcers/injuries. Section M-Skin Conditions, M1200. Skin and Ulcer/Injury Treatments failed to indicate that pressure ulcer/injury care was provided.</p> <p>Review of Resident R152's clinical admission progress note dated 10/29/24, revealed under Skin, a coccyx pressure injury, present on admission, length 3 cm (centimeters), width 3 cm, depth 0 cm, undermining: No, Tunneling: No.</p> <p>Review of Resident R152's clinical progress notes dated 10/30/24, 11/2/24, and 11/4/24, revealed under Skin, a coccyx pressure injury, present on admission, length 3 cm (centimeters), width 3 cm, depth 0 cm, undermining: No, Tunneling: No.</p> <p>Review of Resident R152's physician order dated 11/2/24, indicated Cleanse R (right) buttocks wound with wound cleanser. Apply medihoney (wound treatment with antibacterial properties) and a bordered foam dressing, every night shift for wound care.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 12/12/24, at 9:55 a.m., Registered Nurse Assessment Coordinator (RNAC) Employee E1 confirmed that Resident R152's MDS dated [DATE], under Section M-Skin Conditions was coded incorrectly due to resident having a pressure ulcer/injury on admission and as of 11/2/24, treatment orders to care for pressure ulcer/injury.</p> <p>Review of the facility's Pressure Sore List dated 12/8/24, failed to indicate that Resident R152 had a pressure ulcer/injury.</p> <p>Further review of Resident R152's clinical record failed to reveal weekly pressure ulcer/injury documentation by facility from 11/10/24, through 12/7/24.</p> <p>Review of facility provided document dated 12/10/24, revealed documentation that Resident R152's wound was evaluated by Wound Care Nurse Consultant Employee E29, who identified wound location: Right Buttocks, Wound Type: Pressure ulcer, Wound Status: Not healed, Measurements (cm): 3.5x2.5x0.1, Stage: Stage 2 Pressure injury.</p> <p>During an interview on 12/12/24, at 9:05 a.m., the Director of Nursing (DON) confirmed the facility failed to complete weekly pressure ulcer/injury documentation for Resident R152, from 11/10/24, through 12/7/24.</p> <p>During an interview on 12/12/24, at 1:00 p.m. the DON confirmed the facility failed to make certain that residents were monitored, assessed, and received the necessary services to prevent pressure ulcers/wounds from developing or worsening for three of three residents (Residents R140, R150, and R152).</p> <p>28 Pa. Code 201.18 (b)(1) Management.</p> <p>28 Pa. Code 211.10 (c)(d) Resident care policies.</p> <p>28 Pa. Code 211.12 (d)(1)(2)(3)(5) Nursing services.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46336</p> <p>Based on review of facility policy, clinical records, observations, and staff interviews it was determined that the facility failed to ensure that residents received consistent post fall monitoring for two of seven residents (Residents R15 and R79).</p> <p>Findings include:</p> <p>Review of the facility policy Fall Management dated 11/1/24, indicated when a resident is found on the floor, the facility is obligated to investigate into how the resident got there and put into place an intervention to minimize it from recurring. This will be documented in the residents care plan and progress notes.</p> <p>Review of Residents R15's admission record indicated she was admitted on [DATE].</p> <p>Review of Residents R15's Minimum Data Set (MDS - a periodic assessment of care needs) dated 11/2/24, indicated she had diagnoses that included diabetes (a long-term condition in which the body has trouble controlling blood sugar and using it for energy), renal insufficiency (condition where the kidneys lose the ability to remove waste and balance fluids), and obstructive uropathy (structural or functional hindrance of urine flow).</p> <p>Review of Residents R15's care plan dated 11/20/24, indicated they were at risk of falls.</p> <p>Review of Resident R15's incident report dated 12/7/24, at 6:42 p.m. indicated notified by Nurse Aide (NA) Employee E9 that they lowered resident to the floor while transferring resident to the toilet. No injuries noted. Resident assisted back to the chair with mechanical lift (machine that lifts a resident from point A to point B) and assist of two staff.</p> <p>Review of Resident R15's progress notes failed to include an account of the fall and failed to include ongoing monitoring of the post fall documentation for every shift for seventy-two hours as required.</p> <p>Review of Resident R15's vital signs log failed to include a full set of vital signs for monitoring post fall status for every shift for seventy-two hours as required.</p> <p>Review of Post Fall Review form indicated it was not completed until 12/9/24 at 1:21 p.m.</p> <p>Review of Resident R15's care plan failed to include an updated intervention for post fall changes relating to the fall on 12/7/24.</p> <p>Interview with the Director of Nursing (DON) on 12/10/24, at 11:-00 a.m. indicated the facility should document a progress note and vital signs every shift for seventy-two hours post fall and confirmed that Resident R15's post fall monitoring was not consistently completed as required.</p> <p>Review of the admission record indicated Resident R79 admitted to the facility on [DATE].</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident R79's MDS dated [DATE], indicated the diagnoses of renal insufficiency, anemia (the blood doesn ' t have enough healthy red blood cells), and peripheral vascular disease (a condition in which narrowed blood vessels reduce blood flow to the limbs).</p> <p>Review of Resident R79's care plan indicated at risk for falls due to unsteady gait.</p> <p>Review of Resident R79's incident report dated 12/7/24, at 6:36 p.m. indicated notified by Nurse Aide (NA) that while transferring resident, his legs gave out and resident was assisted to the floor. Resident stated his legs felt weak. Assessed for injuries by nurse, none noted at this time.</p> <p>Review of Resident R79's progress notes failed to include an account of the fall and failed to include ongoing monitoring of the post fall documentation for every shift for seventy-two hours as required.</p> <p>Review of Resident R79's vital signs log failed to include a full set of vital signs for monitoring post fall status for every shift for seventy-two hours as required.</p> <p>Review of Resident R79's current care plan failed to include an updated intervention for post fall changes relating to the fall on 12/7/24.</p> <p>Interview with Registered Nurse (RN) Employee E8 on 12/11/24, at 10:26 a.m. confirmed that Resident R79's post fall monitoring was not consistently completed as required every shift for seventy-two hours post fall for Resident R79.</p> <p>Interview on 12/12/24, at 1:00 p.m. the DON confirmed the facility failed to ensure that residents received consistent post fall monitoring for two of seven residents (Residents R15 and R79).</p> <p>28 Pa. Code: 201.14(a) Responsibility of licensee.</p> <p>28 Pa. Code: 201.18(e)(1) Management.</p> <p>28 Pa. Code: 207.2(a) Administrator's responsibility.</p> <p>28 Pa. Code: 211.10(d) Resident care policies.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395826	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/12/2024
NAME OF PROVIDER OR SUPPLIER Highland Hills Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 1105 Perry Highway Pittsburgh, PA 15237	
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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46336</p> <p>Based on facility policy, clinical record review, and staff interviews, it was determined that the facility failed to ensure that appropriate treatment and services were provided for two of four with an indwelling urinary catheter (Residents R12 and R97) and one of two residents with an external urinary catheter (R65).</p> <p>Findings include:</p> <p>Review of the facility policy Dignity dated 11/1/24, indicated each resident shall be cared for in a manner that promotes enhances resident sense of well-being, feelings of self-worth and self-esteem. Demeaning practices and standards of care that compromise dignity are prohibited. Staff are expected to help the resident to keep urinary catheter bags covered.</p> <p>Review of the admission record indicated Resident R12 was admitted to the facility on [DATE].</p> <p>Review of Resident R12's Minimum Data Set (MDS- a periodic assessment of care needs) dated 9/21/24, indicated the diagnoses of anemia (the blood doesn ' t have enough healthy red blood cells), obstructive uropathy (structural or functional hindrance of urine flow), and anxiety (intense, excessive, and persistent worry and fear about everyday situations).</p> <p>Review of Resident R12's physician orders dated 11/5/24, indicated indwelling foley catheter 16 FR with 10 cc (cubic centimeter) balloon to bedside straight drainage.</p> <p>Review of Resident R12's care plan dated 12/2/24, indicated privacy cover to catheter bag as indicated to promote dignity.</p> <p>Observation on 12/8/24, at 9:00 a.m. Resident R12 was lying in the bed. The drainage bag was connected to the bed frame and not covered with a privacy bag.</p> <p>Review of the admission record indicated Resident R97 was admitted to the facility on [DATE] with the diagnoses of multiple sclerosis (immune system eats away at protective covering of nerve cells), atrial fibrillation (irregular heart rhythm), and high blood pressure.</p> <p>Review of Resident R97's physician orders dated 11/19/24, indicated change indwelling foley catheter 16 FR with 10 cc (cubic centimeter) balloon to gravity drainage bag. Change every month on the 15th and catheter is in a privacy bag at all times. Acetic acid (a natural acidic substance used to flush a foley catheter to prevent infection and calcium buildup) 0.25% (percent) use 50 mls (milliliters) as needed to flush foley catheter.</p> <p>Review of Resident R97's care plan dated 11/20/24, indicated resident will have no complications related to indwelling catheter use.</p> <p>(continued on next page)</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Observation on 12/8/24, at 10:00 a.m. Resident R97 was lying in the bed. The drainage bag was connected to the bed frame and not covered with a privacy bag. On the bedside table a bottle of acetic acid 0.25% was noted to be open without a date. An irrigation syringe was in an irrigation bottle, plunger intact, without a date.</p> <p>Interview on 12/8/24, at 10:10 a.m. RN Employee E4 confirmed the privacy bags were not intact for Resident R12 and R97 and that the acetic acid solution was not stored properly and was not dated.</p> <p>Observation on 12/10/24, at 11:15 a.m. Resident R12's catheter was not covered with a privacy bag.</p> <p>Observation on 12/10/24 at 11:16 a.m. Resident R97's catheter was not covered with a privacy bag.</p> <p>Interview on 12/10/24, at 11:18 a.m. with RN Employee E8 confirmed Resident R12 and Resident R97 did not have privacy covers to their catheters as required.</p> <p>Interview on 12/12/24, at 1:00 p.m. the Director of Nursing confirmed the facility failed to ensure that appropriate treatment and services were provided for two of four with an indwelling urinary catheter (Residents R12 and R97).</p> <p>Review of the medical record indicated Resident R65 was admitted to the facility on [DATE].</p> <p>Review of R65's MDS dated [DATE], indicates the diagnosis of anemia, multiple sclerosis (MS- a neurological disorder that affects the central nervous system), and anxiety.</p> <p>Review of Resident R65's care plan dated 11/6/24, indicated may use Pure Wick external catheter system as desired. Resident R65 is able to place independently.</p> <p>During an interview completed on 12/11/24, at 1:00 p.m. upon asking Resident R65 about using the Pure Wick catheter system Resident R65 stated, it is a God send, my sisters got it for me to use for my son's wedding. The nurse came in and showed me how to use it, there is also a book, and we watched a video.</p> <p>Review of Resident R65's physician orders on 12/11/24, failed to include orders for the usage of the Pure Wick system.</p> <p>During an interview on 12/11/24, at 1:05 p.m. the Director of Nursing (DON) confirmed there were no orders in place for use of the Pure Wick external catheter system and that the facility failed to ensure that appropriate treatment and services were provided for one of two residents with an external urinary catheter (R65).</p> <p>28 Pa. code: 201.14 (a) Responsibility of licensee.</p> <p>28 Pa. Code: 201.18 (b) (1) (e) (1) Management.</p> <p>28 Pa. Code: 211.10 (d) Resident care policies.</p> <p>28 Pa. Code: 211.12 (d) (1) (2) (5) Nursing services.</p>		

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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p>49469</p> <p>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 three or three residents reviewed (Residents R139, R143, and R259).</p> <p>Findings Include:</p> <p>Review of facility policy Enteral Nutrition dated 11/1/24, indicated that 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:</p> <ul style="list-style-type: none"> a. the enteral nutrition product; b. delivery site (tip placement); c. the specific enteral access device (nasogastric, gastric, jejunostomy tube, etc); d. administration method (continuous, bolus, intermittent); e. volume and rate administration; f. the volume/rate goals and recommendations for advancement towards these; and g. instructions for flushing (solution, volume, frequency, timing and 24 hour volume). <p>Review of Resident R139's MDS (Minimum Data Set - periodic assessment of resident care needs) dated 10/15/24, indicates reentry to facility on 10/8/24, with the diagnosis of anemia (low iron in the blood) gastroesophageal reflux disease (GERD- stomach acid repeatedly flows back up into the esophagus causing heartburn and other problems) and anxiety. Section K - Swallowing/Nutritional Status, K05208B indicated Resident R139 had a tube feeding.</p> <p>Review of Resident R139's physician orders 11/25/24, indicates enteral feed five times a day bolus. Jevity 1.5 360 milliliter (ml) five times a day and failed to indicate specific enteral access device being used to administer enteral nutrition formula.</p> <p>During an interview on 12/10/24, at 1:10 p.m. Registered Dietitian (RD) Employee E27 confirmed that Resident R139's physician order for enteral nutrition failed to contain the specific enteral access device for enteral nutrition support.</p> <p>Review of clinical record indicated Resident R143 was admitted to facility on 10/15/24.</p> <p>(continued on next page)</p>		

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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident R143's Minimum Data Set (MDS - a periodic assessment of care needs) dated 10/22/24, indicated diagnoses of hemiplegia (one-sided paralysis) and hemiparesis (one-sided weakness) following unspecified cerebrovascular disease affecting left dominant side, chronic obstructive pulmonary disease (progressive lung disease causing obstructive airflow and breathing difficulties), and hydrocephalus (condition characterized by excess fluid build-up in fluid-containing cavities of the brain, which results in developmental, physical, and intellectual impairments). Section K - Swallowing/Nutritional Status, K0520B indicated Resident R143 had a feeding tube.</p> <p>Review of Resident R143's physician order dated 10/15/24, indicated Enteral feed order every shift, Jevity 1.5 CAL Administer bolus via pump 85 ml (milliliters) per hour x 16 hours. Physician order failed to indicate total volume of enteral nutrition formula Jevity 1.5 to administer over 16 hour period, and also failed to indicate specific enteral access device being used to administer enteral nutrition formula.</p> <p>Review of clinical record indicated Resident R259 was admitted to facility on 11/21/24.</p> <p>Review of Resident R259's Minimum Data Set (MDS - a periodic assessment of care needs) dated 11/27/24, indicated diagnoses of diabetes mellitus, major depressive disorder and dysphagia (difficulty swallowing). Section K - Swallowing/Nutritional Status, K0520B indicated Resident R259 had a feeding tube.</p> <p>Review of Resident R259's physician order dated 11/26/24, indicated Enteral feed order every shift, Osmolite 1.5 cal, 60 ml per hour. Free water flush 30 ml Q4H. Physician order failed to indicate specific enteral access device being used to administer enteral nutrition formula.</p> <p>During an interview on 12/10/24, at 12:55 p.m., Registered Dietitian (RD) Employee E27 confirmed that Resident R139's, R143's, and R259's physician order for enteral nutrition failed to contain the total volume for administration and specific enteral access device for enteral nutrition support. RD Employee E27 confirmed that the facility failed to provide appropriate care and services to residents receiving tube feedings.</p> <p>28 Pa. Code: 201.18(b)(1) Management.</p> <p>28 Pa. Code: 211.10(c) Resident care policies.</p> <p>28 Pa. Code: 211.12(d)(1) Nursing services.</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49469</p> <p>Based on review of facility policy, observations, staff interviews, and clinical record review, it was determined that the facility failed to provide appropriate respiratory care related to oxygen/nebulizer management for two of three residents (Residents R39 and R121).</p> <p>Findings include:</p> <p>Review of the facility policy Oxygen Therapy - Mask and Cannula dated 11/1/24, indicated when masks and cannulas are not in use, store in a plastic bag obtained from central services. Change the humidifier water bottle every 10 days (Note: humidifier bottle must be dated).</p> <p>Review of the admission record indicated Resident R39 was admitted to the facility on [DATE].</p> <p>Review of Resident R39's Minimum Data Set (MDS- a periodic assessment of care needs) dated 9/30/24, indicated the diagnoses of anemia (the blood doesn't have enough healthy red blood cells), stroke (damage to the brain from an interruption of blood supply), and high blood pressure.</p> <p>Review of Resident R39's physician orders dated 10/30/24, indicated albuterol sulfate nebulization (turns liquid medicine into a mist that can be inhaled) solution as needed for wheezing.</p> <p>Review of Resident R39's current care plan failed to include goals and interventions for the nebulizer medication and respiratory concerns.</p> <p>Observation on 12/8/24, at 8:59 a.m. Resident R39's nebulizer was noted to be sitting on the bedside table not stored in a plastic bag as required.</p> <p>Interview on 12/8/24, at 9:15 a.m. Registered Nurse (RN) Employee E4 confirmed the nebulizer was not stored in a plastic bag as required.</p> <p>Review of the admission record indicated Resident R121 was admitted to the facility on [DATE].</p> <p>Review of Resident R121's MDS dated [DATE], indicated the diagnosis of hypertension (high blood pressure), hyperlipidemia (high fat in the blood), and chronic obstructive pulmonary disease (COPD- causes breathing problems and restricts airflow). Section O - Special treatments, Procedures, and Programs, Section C1 oxygen therapy, indicated resident R121 received oxygen.</p> <p>Review of Resident R121's physician orders dated 2/18/24, indicates oxygen at 2 liters per minute (lpm) via nasal cannula (device used to deliver oxygen through two prongs into nostrils) continuously.</p> <p>During an observation on 12/8/24, at 8:58 a.m. Resident R121 was in bed with her oxygen on via nasal canula. The nasal canula and humidifier bottle (adds moisture to the airflow to reduce side effects of dryness) failed to be labeled with a date as required.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 12/8/24, at 9:03 a.m. Licensed Practical Nurse Employee E23 confirmed Resident R121's oxygen tubing and humidifier bottle failed to be labeled with a date as required.</p> <p>Interview on 12/12/24, at 1:00 p.m. the Director of Nursing (DON) confirmed the facility failed to provide appropriate respiratory care related to oxygen/nebulizer management for two of three residents (Residents R39 and R121).</p> <p>28 Pa. code: 201.14 (a) Responsibility of licensee.</p> <p>28 Pa. Code: 201.18 (b) (1) (e) (1) Management.</p> <p>28 Pa. Code: 211.10 (d) Resident care policies.</p> <p>28 Pa. Code: 211.12 (d) (1) (2) (5) Nursing services.</p>

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide safe, appropriate dialysis care/services for a resident who requires such services.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41984</p> <p>Based on review of facility policy, clinical record and staff interview it was determined that the facility failed to make certain consistent dialysis communication was maintained and failed to maintain an accurate care plan for dialysis access site for three of three dialysis resident (Resident R14, R33, and R48).</p> <p>Findings include:</p> <p>Review of the facility policy End-Stage renal disease, how to care for residents with dated, 11/1/24, indicated agreements between this facility and contracted ESRD facility include all aspects of how the resident's care will be managed including how information will be exchanged between facilities.</p> <p>Review of the admission record indicated Resident R14 was admitted to the facility on [DATE].</p> <p>Review of Resident R14's Minimum Data Set (MDS - a periodic assessment of care needs) dated 10/1/24, indicated the diagnoses of diabetes mellitus, dependance on renal dialysis, and end stage renal disease.</p> <p>Review of current physician orders on 9/24/24, indicated Resident R14 attends dialysis on Monday, Wednesday, and Friday each week.</p> <p>A review of the clinical record did not include complete communication forms since on 10/1/24. There were nine incomplete communication sheets (dialysis portion, and facility medications missing) for the following dates: 10/4/24, 10/16/24, 10/25/24, 10/30/24, 11/1/24, 11/8/24, 11/18/24, 11/22/24 and 12/6/24.</p> <p>Review of the admission record indicated Resident R33 was admitted to the facility on [DATE].</p> <p>Review of Resident R33's MDS dated [DATE], indicated the diagnosis of anemia (low iron in the blood), end stage renal disease (kidneys permanently fail to work), and dependence on renal dialysis.</p> <p>Review of Resident R33's physician orders dated 12/30/22, indicated Resident R33 attends dialysis on Monday, Wednesday, and Friday each week.</p> <p>A review of resident R33's clinical record did not include complete communication dialysis forms since 11/1/24, there were two incomplete forms (not completed by dialysis and not completed by facility on return) dated 11/1/24, and 1/6/24, and three days in which no communication sheets were found 11/4/24, 11/15/24, and 11/20/24.</p> <p>During an interview on 12/11/24, at 12:30 p.m. the Director of Nursing (DON) confirmed the dialysis sheets were incomplete or missing and that the facility failed to make certain consistent dialysis communication was maintained.</p> <p>Review of the admission record indicated Resident R48 was admitted to the facility on [DATE].</p> <p>(continued on next page)</p>		

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident R48's Minimum Data Set (MDS - a periodic assessment of care needs) dated 9/7/24, indicated the diagnoses of stage 5 chronic kidney disease.</p> <p>Review of current physician orders on 4/28/24, indicated Resident R48 attends dialysis on Monday, Wednesday, and Friday each week.</p> <p>A review of the clinical record did not include complete communication forms since on 11/1/24. There were four incomplete communication sheets (dialysis portion, and facility medications missing) for the following dates: 11/30/24, 12/3/24, 12/5/24, and 12/7/24.</p> <p>Interview on 11/9/24, at 10:00 a.m. with Unit Manager Employee E8 confirmed incomplete dialysis communication for three of three resident's as required.</p> <p>28 Pa. Code: 201.14(a) Responsibility of licensee.</p> <p>28 Pa. Code: 211.10(d) Resident care policies.</p> <p>28 Pa. Code: 201.18 (b)(1)(e)(1) Management.</p> <p>28 Pa. Code: 211.12 (d)(1)(2)(5) Nursing services.</p>		

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<p>F 0699</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care or services that was trauma informed and/or culturally competent.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49469</p> <p>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 one of two residents (Resident R110).</p> <p>Findings include:</p> <p>Review of the facility policy Care Plans, Comprehensive Person Centered dated 3/5/24, last reviewed 11/1/24, indicates a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial, and functional needs is developed and implemented for each resident.</p> <p>Review of the clinical record indicated Resident R110 was admitted to the facility on [DATE].</p> <p>Review of Resident R110's Minimum Data Set (MDS - a periodic assessment of care needs) dated 10/16/24, indicated diagnoses of Post Traumatic Stress Disorder (PTSD- a disorder that develops when a person has experienced or witnessed a scary, shocking, terrifying, or dangerous event), anxiety, and depression.</p> <p>Review of Resident R110's care plan dated 6/5/24, indicated that resident had PTSD but failed to identify what the triggers were and how to avoid them.</p> <p>During an interview on 12/10/24, at 12:27 p.m. the Director of Nursing (DON) confirmed that the facility failed to identify PTSD triggers for Resident R110 in order to eliminate or mitigate any triggers that may cause re-traumatization for the resident.</p> <p>28 Pa. Code: 201.14(a) Responsibility of licensee.</p> <p>28 Pa. Code: 201.18(b)(1) Management</p>

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.</p> <p>46336</p> <p>Based on review of facility policy, meal observations, resident interviews, and staff interviews 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 for five of five breakfast meal observations on the Arcadia Unit (12/8/24, 12/9/24, 12/10/24, 12/11/24, and 12/12/24).</p> <p>Findings include:</p> <p>The Facility Assessment document dated Quarter 4, 2024, indicated that facility has a wide range of cognitive needs including those that are memory impaired, with dementia or Alzheimer's, and mental issues.</p> <p>The facility Staffing, Sufficient and Competent Nursing policy dated 11/1/24, indicated that the facility provides sufficient numbers of nursing staff. Factors considered in determining appropriate staffing ratios and skills include and evaluation of the diseases, conditions, physical or cognitive limitations of the resident population, and acuity. Minimum staffing requirements imposed by the state, are adhered to when determining staff ratios but are not necessarily considered a determination of sufficient and competent staffing.</p> <p>Review of the facility's Licensed Practical Nurse (LPN) job description indicated to provide direct nursing care to the residents, and to supervise the day-to-day nursing activities performed by nursing assistants.</p> <p>Review of the facility's Certified Nursing Assistant (NA) job description indicated that the NA's primary purpose of the position is to provide each of the assigned residents with routine daily nursing care and services.</p> <p>Review of the facility's staffing sheet dated 12/8/24, indicated one LPN and two NA's assigned to the 28 residents.</p> <p>Review of the facility's Food Cart Times indicated the Arcadia unit trays arrived at 8:45 a.m. and 8:50 a.m.</p> <p>During an observation on 12/8/24, at 9:25 a.m. Licensed Practical Nurse (LPN) Employee E18 arrived at the Arcadia Unit dining room and began to prep (open containers, utilize condiments, cut foods) meal trays for service to the residents. Nurse Aide (NA) Employee E19 and NA Employee E20 were bringing the remaining residents into the dining room and started to serve the trays.</p> <p>Interview with NA Employee E19, on 12/8/24, at 9:30 a.m. indicated this was a typical day, as the residents were not permitted to eat in their rooms and needed supervised and help with eating. NA Employee E19 indicated It would be nice if we had three NA's.</p> <p>Review of the facility staffing sheet dated 12/9/24, indicated one LPN and 3 NA's.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395826	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/12/2024
NAME OF PROVIDER OR SUPPLIER Highland Hills Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 1105 Perry Highway Pittsburgh, PA 15237	
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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an observation on 12/9/24, at 8:59 a.m. the first food cart was delivered and placed inside the dining room by dietary staff. All residents were lined up outside the closed dining room door.</p> <p>During an observation on 12/9/24, at 9:02 a.m. the second food cart was delivered and placed inside the dining room by dietary staff. Residents remained lined up outside the closed dining room door.</p> <p>Further observation on 12/9/24, at 9:15 a.m. the residents had been assisted into the dining room and meal service began. The last meal was served at approximately 9:43 a.m.</p> <p>Interview with NA Employee E21 on 12/9/24, at 9:45 a.m. indicated she was agency, and this was only her fourth shift at the facility, and she didn't really know anybody or where they sat in the dining room.</p> <p>Review of the facility staffing sheet dated 12/10/24, indicated one LPN and 3 NA's.</p> <p>Observations on 12/10/24, at 9:45 a.m. the breakfast meal was still being passed in the dining room.</p> <p>Interview on 12/10/24, at 9:48 a.m. NA Employee E19 indicated being the only regular NA on the floor, which makes things go a lot slower during the process of getting residents out of bed, into the dining room, served and assisted with feeding.</p> <p>Review of the facility staffing sheet dated 12/11/24, indicated one LPN and two NA's.</p> <p>Observations on 12/11/24, at 9:03 a.m. two regular NA's on the floor. Two food carts were sitting full of food, untouched by staff inside the entrance doors to the unit.</p> <p>Review of the Meal Cart Times indicated the carts had arrived at 8:45 a.m. and 8:50 a.m.</p> <p>Observation on 12/11/24, at 9:16 a.m. Office Personnel E22 arrived to assist passing trays in the Arcadia Dining Room and to continue to bring residents in from the hallways of the unit into the dining room.</p> <p>Registered Nurse (RN) Employee E24, arrived at the unit on 12/11/24, at 9:16 a.m. to assist with breakfast on the Arcadia Unit.</p> <p>Interview on 12/11/24, at 9:16 a.m. RN Employee E23 indicated she was not that familiar with the Arcadia unit as she is from the second floor. Since census was lower upstairs, she was helping in Arcadia today.</p> <p>Observation on 12/11/24, at 9:35 a.m. the last resident meal was served.</p> <p>Review of the facility staffing sheet dated 12/12/24, indicated one LPN and two NA's.</p> <p>Observation on 12/12/24, at 9:40 a.m. indicated one regular NA on the floor. Breakfast meal was still in process.</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 12/12/24, at 9:40 a.m. NA Employee E20 indicated she was the regular NA for the day, and it was a slower process today with only two aides. We're still getting residents out of bed and bringing them to the dining room. The food carts sat untouched.</p> <p>Interview on 12/12/24, at 9:45 a.m. the Director of Nursing (DON) confirmed 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 for five of five breakfast meal observations on the Arcadia Unit (12/8/24, 12/9/24, 12/10/24, 12/11/24, and 12/12/24).</p> <p>28 Pa. code: 201.14(a) Responsibility of licensee.</p> <p>28 Pa. Code: 201.18(b)(1)(e)(1) Management.</p> <p>28 Pa. Code: 211.10(d) Resident care policies.</p> <p>28 Pa. Code: 211.12(d)(1)(2)(5) Nursing services.</p>

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46336</p> <p>Based on review of facility policies, observations, and staff interviews, it was determined that the facility failed to store medications properly and securely in three of six medications carts (LTC cart 1, LTC cart 2, and Grand Heritage cart) and medications found unsecured at resident's bedside for three of 10 residents (Residents R2, R105, and R110).</p> <p>Findings include:</p> <p>Review of the facility policy Medication Labeling and Storage dated 11/1/24, indicated multi-dose (used more than once) medications that have been opened or accessed are dated and discarded within 28 days unless the manufacturer specifies a shorter or longer date.</p> <p>During an observation on 12/8/24, at 11:00 a.m. of LTC medication cart 1 indicated the following medications opened and undated:</p> <ul style="list-style-type: none"> -Resident R66's Humalog insulin (a rapid acting insulin). -Resident R32's Solostar (prefilled pen to inject long-acting insulin under the skin). <p>Interview with Licensed Practical Nurse (LPN) Employee E25 confirmed the medications for Resident R66 and Resident R32 were opened and not dated as required.</p> <p>During an observation on 12/8/24, at 11:35 a.m. of Grand Heritage medication cart indicated the following medications opened and undated:</p> <ul style="list-style-type: none"> -Resident R132's B12 injection (treats forms of anemia and B12 deficiency), and Fluticasone (relieves stuffy, runny nose) nasal spray. -Resident R 98's ipratropium bromide (treats airflow blockage) aerosol, and Albuterol (used for wheezing) inhaler. -Resident R67's ipratropium bromide aerosol. -Resident R11's Albuterol inhaler. -Resident R50's Albuterol inhaler. <p>Interview on 12/8/24, at 11:35 a.m. with LPN Employee E26 confirmed the medications for Resident R132, Resident R98, Resident R67, Resident R11, and Resident R50 were opened and not dated as required.</p> <p>During an observation on 12/8/24, at 11:40 a.m. of LTC medication cart 2 indicated the following medications opened and undated:</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-Resident R123's albuterol nebulizer.</p> <p>-Resident R85's fluticasone.</p> <p>Interview on 12/8/24, at 11:40 a.m. LPN Employee E25 confirmed the medications for Resident R123, and Resident R85 were opened and not dated as required.</p> <p>Observation on 12/8/24, at 8:57 a.m. Resident R105 had an Albuterol inhaler unsecured on his bedside stand.</p> <p>Observation on 12/8/24, at 9:00 a.m. Resident R2's bedside stand drawer was sitting open. Inside was a bottle of TUMS (antacid medication) unsecured.</p> <p>Interview on 12/8/24, at 9:13 a.m. Registered Nurse (RN) Employee E4 confirmed the medications for Resident R105 and Resident R2 were unsecured and should have been in the locked medication cart.</p> <p>Review of the admission record indicated Resident R110 was admitted to the facility on [DATE].</p> <p>Review of Resident R110's MDS dated [DATE], indicated the diagnosis of anxiety, depression and post-traumatic stress disorder (PTSD- a mental disorder that develops after a traumatic event).</p> <p>Review of Resident R110's progress notes dated 12/7/24, at 8:43 p.m. indicates alerted to residents room about 35 minutes prior to this note because resident had call bell on. This nurse took residents medications in to him and i was accompanied by a NA. resident requested that his dinner tray be moved to his bed side table, NA provided, resident requested urinal be emptied and this nurse emptied per resident request, resident holding medication cup in his hand and refused to take prior to this nurse leaving room, this nurse explained that i could not leave medication in room , resident became irate asking this nurse and NA where our state validated ids were and that he was going to have us fired for medical malpractice, i explained to resident that we were temporary staff working in the facility to help care for the residents, resident started screaming saying that people were outside of his room playing loud music and banging on his walls and making tik toks, i explained to resident that i had been out in hall for quite some time and i did not observe anyone banging on walls or making tik toks, the resident in room [ROOM NUMBER] was watching a music show on his tv earlier in shift and it was playing loudly, tv was not playing at the time this nurse went into the room to answer resident call bell , resident refused to take his medication and refused to give it back to this nurse, i observed the resident hide his medication under a towel on his bed, resident started screaming STOP over and over, this nurse made sure resident was safe and i exited the room, RN supervisor was made aware of the situation.</p> <p>Interview on 12/11/24, at 11:00 a.m. the Director of Nursing (DON) confirmed that the progress note dated 12/7/24, at 8:43 p.m. indicated Resident R110's medications were left unsecured in his room.</p> <p>Interview on 12/12/24, at 1:00 p.m. the Director of Nursing confirmed the that the facility failed to store medications properly and securely in three of six medications carts (LTC cart 1, LTC cart 2, and Grand cart), and medications found unsecured at resident's bedside for three of 10 residents (Residents R2, R105, and R110).</p> <p>28 Pa. Code 211.9(a)(1) Pharmacy services.</p> <p>(continued on next page)</p>		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	28 Pa. Code 211.12(d)(1)(5) Nursing services.

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<p>F 0810</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide special eating equipment and utensils for residents who need them and appropriate assistance.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41984</p> <p>Based on observations, and staff interviews it was determined that the facility failed to provide adaptive feeding devices for one of three residents (Resident R87).</p> <p>Findings include:</p> <p>Review of the admission record indicated Resident R87 admitted to the facility on [DATE].</p> <p>Review of Resident R87's Minimum Data Set (MDS- a periodic assessment of care needs) dated 10/14/24, indicated diagnoses of diabetes mellitus, irritable bowel syndrome, and chronic pain.</p> <p>Review Resident R87's physician order dated 10/22/24, indicated a CCD (Controlled Carbohydrate diet), regular texture, thin liquids.</p> <p>During an observation on 12/8/24, at 8:45 a.m. Resident R87's breakfast tray was observed on the bedside table. The meal ticket indicated sippy cup.</p> <p>During an interview and observation on 12/9/24, at 9:05 a.m. Registered Nurse (RN) Employee E17 indicated a sippy cup was not served as ordered on the tray, two regular cups were present.</p> <p>Interview on 12/9/24, at 2:15 p.m. the Nursing Home Administrator (NHA) confirmed the facility failed to provide adaptive feeding devices for one of five residents (Resident R87).</p> <p>28 Pa. Code: 211.6(a) Dietary services.</p> <p>28 Pa Code: 201.29 (d) Resident rights.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41984</p> <p>Based on review of facility policy, observations and staff interview, it was determined that the facility failed to properly store food products in dry storage, walk in cooler, reach in cooler and failed to maintain sanitary conditions in the dish room which created the potential for cross contamination (Main Kitchen).</p> <p>Findings include:</p> <p>Review of facility policy Sanitation dated 11/1/24 indicates the food service area shall be maintained in a clean and sanitary manner.</p> <p>During an observation of the main designated kitchen on 12/8/24, at 8:45 a.m. the following was observed:</p> <p>Walk in cooler:</p> <ul style="list-style-type: none"> -ground beef (6) thawing on the 2nd shelf -deli turkey (1)- no date -bag salad mix (1) - no date <p>Dry storage:</p> <ul style="list-style-type: none"> -metal bowl of raisin bran, no cover, label, date -liquid better (3) - no date -oatmeal cream pies (23) - no date -[NAME] buddies (4) - no date <p>Reach in cooler</p> <ul style="list-style-type: none"> -American cheese (1) - no label or date -boiled eggs (1) - no label or date -hot dogs (2) - no label or date <p>During an observation of the main designated kitchen on 12/8/24, at 1:30 p.m. the following was observed:</p> <ul style="list-style-type: none"> -Wall fan in dish room, brown debris <p>(continued on next page)</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>-Walls in dish room, food/brown debris</p> <p>-Ice machine, brown, slimy substance</p> <p>During an interview on 12/8/24, at 2:30 p.m. Dietary Manager (DM) Employee E14 confirmed that the facility failed to properly store food products and maintain sanitary conditions which created the potential for food borne illness and cross contamination in the Main Kitchen.</p> <p>28 Pa. Code: 201.14(a) Responsibility of licensee.</p> <p>28 Pa. Code: 201.18(b)(1) Management.</p>		

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<p>F 0868</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>45577</p> <p>Have the Quality Assessment and Assurance group have the required members and meet at least quarterly</p> <p>Based on review of facility documents and staff interview, it was determined that the facility failed to conduct Quality Assessment and Assurance (QAA) meetings at least quarterly with all of the required committee members for one of four quarters (April 2024, through June 2024).</p> <p>Findings include:</p> <p>Review of the CFR (Code of Federal Regulations)</p> <p>S483.75(g) Quality assessment and assurance.</p> <p>S483.75(g) Quality assessment and assurance.</p> <p>S483.75(g)(1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of:</p> <p>(i) The director of nursing services;</p> <p>(ii) The Medical Director or his/her designee;</p> <p>(iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and</p> <p>(iv) The infection Preventionist.</p> <p>Review of Quality Assurance and Performance Improvement (QAPI) sign-in sheets and attendance records from the period of April 2024, through June 2024, did not reveal that the Medical Director/designee was in attendance.</p> <p>During an interview on 12/12/24, at 8:51 a.m., the Nursing Home Administrator (NHA) confirmed that the facility failed to conduct Quality Assessment and Assurance (QAA) meetings at least quarterly with all of the required committee members as required.</p> <p>28 Pa Code: 201.18(e)(1)(2)(3)(4) Management.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>49469</p> <p>Provide and implement an infection prevention and control program.</p> <p>Based on facility policy, clinical record review, observation, and staff interview, it was determined that the facility failed to follow enhanced barrier precautions and failed to implement a care plan containing interventions for enhanced precautions which created the potential for cross-contamination and the spread of diseases and infections for one of four residents (Resident R139).</p> <p>Findings include:</p> <p>Review of the facilities policy Enhanced Barrier Precautions dated 3/5/24, last reviewed 11/1/24, indicates Enhanced barrier precautions (EBPs) are utilized to reduce the transmission of multi-drug resistant organisms to residents. EBP's are indicated for residents with wounds and /or indwelling medical devices.</p> <p>Review of Resident R139's MDS (Minimum Data Set - periodic assessment of resident care needs) dated 10/15/24, indicates reentry to facility on 10/8/24, with the diagnosis of anemia (low iron in the blood) gastroesophageal reflux disease (GERD- stomach acid repeatedly flows back up into the esophagus causing heartburn and other problems) and anxiety. Section K05208B indicated Resident R139 had a tube feeding.</p> <p>During an observation on 12/10/24, at 10:15 a.m. Resident R139's door did not have signage to ensure that employees, visitors, and family members are utilizing PPE, when indicated.</p> <p>During an observation and interview on 12/10/24, at 10:20 a.m. Registered Nurse (RN) Employee E16 confirmed the facility failed to provide signage of EBP on resident R139's door to ensure that employees, visitors, and family members are utilizing PPE, when indicated. Upon asking RN Employee E16 if EBP's interventions are in Resident R139's care plan, RN Employee E16 stated I don't know where the care plans are in the computer, I'm not computer literate, I would have to ask another nurse to find them.</p> <p>During an interview completed on 12/10/24, at 1:00 p.m. the Director of Nursing (DON) confirmed that the facility failed to follow enhanced barrier precautions and failed to implement a care plan containing interventions for enhanced barrier precautions which created the potential for cross-contamination and the spread of diseases and infections for one of four residents (Resident R139).</p> <p>28 Pa. code: 201.14 (a) Responsibility of licensee.</p> <p>28 Pa. Code: 201.18 (b)(1)(e)(1) Management.</p> <p>28 Pa. Code: 211.10 (d) Resident care policies.</p> <p>28 Pa. Code: 211.12 (d)(1)(2)(5) Nursing services.</p>		