STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395860	A. Building B. Wing	01/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Loyalhanna Care Center	535 McFarland Road Latrobe, PA 15650

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 42079 Based on review of policies and clinical records, as well as observations and staff interviews, it was determined that the facility failed to ensure that care-planned interventions for advanced directives were consistently implemented for one of six residents reviewed (Resident 3). Findings include: The facility's policy regarding Do Not Resuscitate orders, dated January 1, 2024, indicated that the interdisciplinary care planning team would review advance directives with the resident during quarterly care planning sessions to determine if the resident wishes to make changes. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 3, dated November 13, 2023, indicated that the resident was usually understood, could sometimes understand, was severely cognitively impaired, required extensive assistance with bathing, and was dependent on staff for transfers and toileting. An advance directive care plan for Resident 3, dated December 28, 2021, indicated that the resident had a code status of do not resuscitate (DNR) and had a physician's order for life sustaining treatment (POLST) reviewed with the facility. An intervention indicated that the POLST would be reviewed upon readmission, quarterly, and with significant changes. Resident 3's POLST, dated December 29, 2021, indicated that he was a DNR with limited interventions. The POLST was reviewed on the phone with the resident's representative and signed by two nurse signatures. The directions for healthcare professionals indicated that the form should be reviewed periodically and a new form completed if necessary when there is a substantial change in the person's health status, a change in treatment preferences, or transfer from one care setting or care level. A nursing note for Resident 3, dated September 19, 2023, indicated that the resident had been discharged from hospice services and would continue to be a resident in long-term care. There was no documented evidence that the POLST was reviewed quarterly or upon a significant change per Resident 3's care plan. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with the Registered Nurse Assessment Coordinator on January 24, 2024, at 4:17 p.m. indicated that she attended the care conferences, and confirmed that Resident 3's POLST was not reviewed and should have been reviewed as care planned due to the resident's recent medical history. 28 Pa. Code 211.12(d)(5) Nursing Services.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 31760 Based on review of Pennsylvania's Nursing Practice Act, facility policies, and residents' clinical records, as well as staff interviews, it was determined that the facility failed to ensure that treatments performed were documented by the nurse who performed the treatment for one of six residents reviewed (Resident 4). Findings include: The Pennsylvania Code, Title 49, Professional and Vocational Standards, State Board of Nursing, 21.18. Standards of nursing conduct (a)(5)(8) indicated that the registered nurse was to document and maintain accurate records. Not to falsify or knowingly make incorrect entries into the patient's record or other related documents. The Pennsylvania Code, Title 49, Professional and Vocational Standards, State Board of Nursing, 21.148. Standards of nursing conduct (a)(5)(8) indicated that the licensed practical nurse was to document and maintain accurate records. Not to falsify or knowingly make incorrect entries into the patient's record or other related documents. The facility's policy regarding charting and documentation, dated January 1, 2023, indicated that documentation of procedures and treatments will include care-specific details, including the name and title of the individual(s) who provided the care. Physician's orders for Resident 4, dated January 15, 2024, included an order for the staff to drain the resident's pigtail catheter (a tube inserted through the chest wall to drain pleural fluid which lubricates the surfaces of the pleura - this is the thin tissue that lines the chest cavity and surrounds the lungs) once daily and record the amount. If the drainage is less than 50 milliliters (ml) for several days, the pigtail catheter may be removed if the attending physician deems it appropriate to be removed. A nursing note for Resident 4, dated January 20, 2024, completed by Registered Nurse 1 revealed that the resident's PleurX (pigtail catheter) was drained by sterile procedure and 190 milliliters (ml) of yellow fluid was removed. The resident tolerated the procedure well. The dressing was changed with no signs or symptoms of infection. However, the resident's Medication Administration Record (MAR), dated January 20, 2024, was signed by Licensed Practical Nurse 2 as the person draining Resident 4's pigtail catheter. A nursing note for Resident 4, dated January 21, 2024, completed by Registered Nurse 1 revealed that the resident's PleurX was drained by sterile procedure and 100 ml of yellow fluid was removed. The resident tolerated the procedure well. The dressing was changed with no signs or symptoms of infection. However, the resident's MAR, dated January 21, 2024, was signed by Licensed Practical Nurse 2 as the person draining the resident's pigtail catheter. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A nursing note for Resident 4, dated January 22, 2024, completed by Registered Nurse 3 revealed that the resident's PleurX was drained by sterile procedure and 200 ml of yellow fluid was removed. The resident tolerated the procedure well. The dressing was changed with no signs or symptoms of infection. However, the resident's MAR, dated January 22, 2024, was signed by Licensed Practical Nurse 4 as the person draining the resident's pigtail catheter. Interview with Registered Nurse 1 on January 24, 2024, at 11:35 a.m. revealed that the registered nurses are the only staff that perform any care to Resident 4's pigtail catheter. Interview with the Director of Nursing on January 24, 2024, at 2:40 p.m. confirmed that staff performing/completing a resident's treatment should be the one documenting in the resident's clinical record. She indicated that the registered nurses were educated on Resident 4's pigtail catheter and that registered nurses are the only ones to be providing care to Resident 4's pigtail catheter. She indicated that if the licensed practical nurses were signing Resident 4's MARs, then they were signing it off for the registered nurse completing the treatment. Interview with Licensed Practical Nurse 2 on January 24, 2024, at 2:47 p.m. revealed that only the registered nurses are to do any care to Resident 4's pigtail catheter, and that if she was signing the MAR, it was because the registered nurse told her to do so. Interview with the Director of Nursing on January 24, 2024, at 2:53 p.m. confirmed that Licensed Practical Nurses 2 and 4 signed Resident 4's MAR on the above dates. 28 Pa. Code 211.12(d)(1)(5) Nursing Services.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31760 Based on review of facility policies and clinical records, as well as staff interviews, it was determined that the facility failed to ensure that residents' clinical records were complete and accurately documented for one of six residents reviewed (Resident 2). Findings include: The facility's policy regarding charting and documentation, dated January 1, 2023, indicated that the following information was to be documented in the resident medical record: Objective observations, changes in a resident's condition, treatments and services performed, and events, incidents, or accidents involving the resident. An admission summary note, dated January 15, 2024, indicated that Resident 2 was admitted on [DATE]. The resident was alert and oriented to person, place and time. A social service note for Resident 2, dated January 18, 2024, indicated that the facility received a call late at night regarding the resident sitting on a bed pan for four hours. Resident 2 told staff she was put on the bed pan but was not removed from it for four hours. Resident 2 stated she did not use her call light to get help, and she yelled for an employee. The resident was educated on importance of using her call light in time of need. Information reported to the Department of Health on January 18, 2024, indicated that Resident 2's family member called the facility and reported that she was left on a bed pan. There was no documented evidence in the medical record that Resident 2 was assessed by a registered nurse or that a skin assessment was completed by staff. Interview with the Assistant Director of Nursing on January 24, 2024, at 12:50 p.m. revealed that she assessed Resident 2 with the supervisor on duty; however, the assessment was not documented in the medical record. 28 Pa. Code 211.5(f) Clinical Records. 28 Pa. Code 211.12(d)(5) Nursing Services.