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	02/21/2024

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 47819 Based on review of policies, clinical records, and the facility's investigation documents, as well as staff interviews, it was determined that the facility failed to ensure that the residents' environment remained as free from accident hazards as possible and failed to develop and implement interventions to prevent falls for one of five residents reviewed (Resident 1). Findings include: The facility's policy for managing falls and fall risk, dated January 1, 2024, indicated that nursing staff in conjunction with the attending physician, consultant pharmacist, therapy staff, and others will seek to identify and document risk factors for falls and establish a resident-centered falls prevention plan based on relevant assessment information. An Admission Minimum Data Set (MDS) assessment (a federally-mandated assessment of the resident's abilities and care needs) for Resident 1, dated January 29, 2024, indicated that the resident was cognitively intact, required assistance from staff with daily care tasks, including transfers and ambulation, had a history of falls, and had diagnosis that included a left humerus fracture, alcohol dependence, and high blood pressure. A care plan for Resident 1, dated January 24, 2024, revealed that the resident was at risk for falls due to impaired vision, hypomagnesemia, and alcohol dependence. A review of nursing notes for Resident 1, dated January 24, 2024, at 10:16 a.m., revealed that the resident sustained an unwitnessed fall in his room. Facility investigation documents, dated January 24, 2024, indicated that the care-planned interventions were to educate and remind the resident to use the pull cord in the bathroom to call for assistance and to wait for help before attempting to transfer off the toilet, remind and educate the resident to use the call light to request assistance with bathing and dressing, and to not attempt to stand at the side of the bed without staff assistance. (continued on next page)

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of nursing notes for Resident 1, dated January 30, 2024, at 6:58 a.m., revealed that the resident sustained an unwitnessed fall in his room and was found on right side of the bed. Facility investigation documents, dated January 30, 2024, indicated that the care-planned intervention was to be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. Staff were to promptly respond to all requests for assistance, remind and redirect the resident if he is noted to be lying on edge of bed, remind and assist the resident with bed mobility and repositioning to ensure that while in bed he is lying towards center to avoid rolling out of bed, and remind and encourage the resident to use his call light to alert staff of need for assistance with bed mobility and repositioning. A review of nursing notes for Resident 1, dated February 10, 2024, at 2:09 a.m., revealed that the resident sustained an unwitnessed fall in his room. Facility investigation documents, dated February 10, 2024, indicated that the care-planned intervention was to remind and reinforce with the resident the need to use the call bell, request assistance for transfers, and wait for help before transferring and ambulating. A review of nursing notes for Resident 1, dated February 11, 2024, at 9:40 a.m. revealed that the resident sustained an unwitnessed fall in his room. Facility investigation documents, dated February 11, 2024, indicated that the care-planned intervention was to remind the resident to utilize call system for assistance with standing. The resident was non-compliant with utilization of call system. Staff were frequently rounding on the resident to address needs and prevent falls. A review of nursing notes for Resident 1, dated February 15, 2024, at 11:31 a.m., revealed that the resident sustained an unwitnessed fall in his room. Facility investigation documents, dated February 15, 2024, indicated that the care-planned intervention was to encourage the resident to ask for help prior to attempting to get out of bed or chair. An interview with the Registered Nurse Assessment Coordinator (RNAC - a registered nurse who is responsible for the completion of MDS assessments) on February 21, 2024, at 3:09 p.m. confirmed that the interventions were repeated, and the resident should have been care planned for new individualized care plans to prevent recurrent falls. An interview with the Registered Nurse Clinical Consultant on February 21, 2024, confirmed that the resident should have had new individualized interventions to prevent recurrent falls. 28 Pa. Code 201.14(a) Responsibility of Licensee. 28 Pa. Code 201.18(b)(1)(e)(1) Management. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing Services.