

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395882	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/18/2024
NAME OF PROVIDER OR SUPPLIER Longwood at Oakmont		STREET ADDRESS, CITY, STATE, ZIP CODE 500 Route 909 Verona, PA 15147	

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 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45577</p> <p>Based on review of facility policy, clinical record review, and staff interview, it was determined that the facility failed to report an allegation of neglect to other officials in accordance with State law, including to the State Survey Agency, within 24 hours, and failed to describe the results of the investigation within five working days of the incident, for one of two residents. (Resident R1).</p> <p>Findings include:</p> <p>Review of the facility policy Skilled Nursing - Abuse, dated 2/7/24, indicated that it is the policy of the community that abuse allegations (abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property) are reported per Federal and State Law.</p> <p>A review of the clinical record revealed that Resident R1 was admitted to the facility on [DATE], with diagnoses encephalopathy (a medical term used to describe a disease that affects brain structure or function; it causes altered mental state and confusion), paroxysmal atrial fibrillation (a type of irregular heartbeat that comes and goes), and hypothyroidism (a condition resulting from decreased production of thyroid hormones).</p> <p>A review of Resident R1's MDS assessment (MDS-Minimum Data Set assessment: periodic assessment of resident care needs) dated 1/3/24, indicated that diagnoses remain current.</p> <p>A review of incident report dated 2/26/24, indicated that a bruise to Resident R1's left inner thigh was identified and noted to be blackish in color, and a large/firm mass surrounding the bruise. No redness or pain at the time. Measures 4.0 cm (centimeters) x 4.8 cm x 0.0 cm with mass of 12.0 cm x 12.0 cm. Notified Charge nurse, CRNP (Certified Registered Nurse Practitioner) and POA.</p> <p>A review of facility submitted documentation on 3/6/24, identified a reportable incident, Event Type: Other.</p> <p>A review of facility provided documents revealed that the initial submission on 3/6/24, was rejected on 3/7/24, requesting that event be resubmitted under neglect. Further review of facility provided documents revealed that facility resubmitted documents on 3/11/24, and event was accepted on 3/11/24, awaiting mandatory abuse reporting forms which were submitted 3/13/24.</p> <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
---	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395882	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/18/2024
NAME OF PROVIDER OR SUPPLIER Longwood at Oakmont		STREET ADDRESS, CITY, STATE, ZIP CODE 500 Route 909 Verona, PA 15147	
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 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 3/18/24, at 10:15 a.m., the Director of Nursing (DON) indicated that she was unable to contact one of the Alleged Perpetrators (AP) identified in the facility submitted documents due to AP resigning day after incident took place, and has been unable to contact her as of this date of on-site survey.</p> <p>During an interview on 3/18/24, at 2:20 p.m., the Nursing Home Administrator (NHA) and Director of Nursing (DON) confirmed that the facility failed to report an allegation of neglect to other officials in accordance with State law, including to the State Survey Agency, within 24 hours, and failed to describe the results of the investigation within five working days of the incident, for one of two residents. (Resident R1).</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: 211.12(d)(1)(5) Nursing services.</p>		