

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 396003	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/30/2024
NAME OF PROVIDER OR SUPPLIER Monroeville Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 885 MacBeth Drive Monroeville, PA 15146	

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 0557</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions.</p> <p>36115</p> <p>Based on observations and staff interviews it was determined that the facility failed to provide a dignified dining experience to the residents during the lunch meal service on October 15, 2024, as required.</p> <p>Findings include:</p> <p>During an observation on 10/15/24, at 10:45 am it was revealed that the facility was utilizing disposable styrofoam bowls to serve the residents their dessert (cinnamon apples) for the lunch meal.</p> <p>During an interview on 11/15/24, at 10:57 am [NAME] Employee E1 confirmed that the facility was utilizing disposable styrofoam bowls to serve the residents their lunch dessert.</p> <p>During an interview on 10/15/24, at 11:15 am Food Service Director Employee E2 confirmed that the facility failed to maintain a supply of china or thermal serving bowls and was utilizing disposable styrofoam bowls to serve residents their dessert which failed to provide the resident with a dignified dining experience as required.</p> <p>PA Code: 201.29(k) Resident rights.</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 0563</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Honor the resident's right to receive visitors of his or her choosing, at the time of his or her choosing.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36115</p> <p>Based on observations and staff interviews it was determined that the facility failed to provide a method for resident visitors to easily access the facility to permit visitation of the resident during off hours (Saturday 10/26/24), as required.</p> <p>Findings include:</p> <p>During an observation on 10/26/24, at 9:18 a.m., the State Agency (SA) attempted to enter the facility. Upon entering the foyer area of the facility there was secured double doors preventing access to the facility. The SA attempted to gain access to the facility by activation of the intercom located on the right of the double doors. Upon activation a door bell sounded. No staff member responded to the door bell or the activated intercom. A notice displayed on the left side double door indicated that during off hours to call the facility's main telephone number that was provided on the posting. The surveyor placed a telephone call to this number. The telephone rang for approximately two minutes and then disconnected failing to be answered by staff or the ability to leave a voice mail message. The SA again attempted to activate the intercom and call then call the facility telephone number with the facility continuing to fail to respond. The SA walked around the side of the building and encountered three staff members at the facility's service entrance. One staff member responded are you not able to enter the building? The SA identified themselves and gained access to the facility through the facility's service entrance.</p> <p>During an interview on 10/26/24, at 9:45 am Receptionist Employee E4 confirmed that her scheduled work hours for a Saturday were from 10:00 am until 4:00 pm and she was uncertain how visitors gained access to the facility if attempting to visit outside of those hours.</p> <p>During an observation on 10/26/24, at 9:50 a.m., it was determined that a notice instructing visitors to activate the intercom by pressing the button on the right was obscured by a fall decorative [NAME]. In addition a notice indicating to call the facility's main telephone number during off hours failed to identify the timeframe for off hours.</p> <p>During an observation on 10/26/24, at 10:00 am it was revealed that the facility's intercom system was non operational and the equipment located at the first floor nursing unit had been removed from the wall leaving exposed wires.</p> <p>During an interview on 10/26/24, at 11:00 am the Nursing Home Administrator and Director of Nursing confirmed that they were aware that the facility's intercom system was non operational and that the facility's main telephone number when left unanswered would disconnect after ringing for approximately two minutes which prevented visitors access to the facility during off hours. It was further confirmed that the facility failed to detail off hours on postings displayed in the facility's foyer entrance which failed to create easy access for visitors to visit residents as required.</p> <p>PA Code: 201.30(a)(b) Access requirements.</p>		

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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36115</p> <p>Based on a review of facility records and staff interviews it was determined that the facility failed to notify the resident's responsible party of two of two room changes (Resident R2) as required.</p> <p>Finding include:</p> <p>During a review of Resident R2's census record it was revealed that the resident had two room changes on 10/16/24. Census records indicated that Resident R2 was moved from room [ROOM NUMBER] bed A to room [ROOM NUMBER] bed A and then to room [ROOM NUMBER] bed A.</p> <p>A review of Resident R2's progress notes failed to provide evidence that the facility notified the resident's guardian/responsible party of the room changes.</p> <p>During an interview on 10/18/24, at 1:41 pm Resident R2's Guardian/Responsible Party RP1 confirmed that the facility failed to notify her of Resident R2's room changes.</p> <p>During an interview on 10/26/24, at 11:00 am information regarding the facility's failure to notify Resident R2's guardian/responsible party of the two room changes was addressed with the Nursing Home Administrator and Director of Nursing.</p> <p>Pa Code: 201.29(a) Resident rights.</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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36115</p> <p>Based on observations and staff interviews it was determined that the facility failed to provide the residents with a homelike environment in room [ROOM NUMBER], the second floor Dining Room, the first floor resident lounge, and the second floor resident lounge. (room [ROOM NUMBER], Second floor Dining Room, First Floor resident lounge, and second floor resident lounge).</p> <p>Findings include:</p> <p>During an observation on 10/26/24, at 11:20 am it was revealed that the ceiling tile for the bathroom in room [ROOM NUMBER] contained a wet spot and brown markings indicating prior leaking water. The ceiling tile was located over the toilet.</p> <p>During an interview on 10/26/24, at 11:25 am Licensed Practical Nurse (LPN) Employee E5 confirmed that the ceiling tile contained brown marks indicating prior leaks and a current wet spot.</p> <p>A review of facility maintenance work orders revealed that a work order was submitted for the repair of the leak and replacement of ceiling tile in room [ROOM NUMBER] due to the resident voicing a concern that he felt water dripping on him when he was using the bathroom facilities on 10/20/24.</p> <p>During a observation of the facility on 10/26/24, it was revealed that the second floor dining room was being utilized by the facility as a storage room failing to provide the resident with an area to dine. In the dining room was stored the following:</p> <ul style="list-style-type: none"> * 6 oxygen concentrators * 6 bed frames * 10 wheelchairs * 4th of July decorations * 26 boxes * 11 IV poles * a housekeeping cart * 7 various floor scrubbing machines * 2 floor fans * 6 mattresses * 1 air mattress <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>	<ul style="list-style-type: none"> * an organ * 2 potty chairs * 3 Hazardous material bins * a steamtable * An elevated toilet seat * a radio * 3 packages of briefs <p>During an observation of the second floor nursing unit it was revealed that the entrance to the resident lounge area contained a broken utility cart blocking the entrance. The door was locked failing to allow residents access to a common area, and the lounge was being utilized as a storage area containing 14 boxes and a hazard material bin .</p> <p>During an observation of the first floor nursing unit it was revealed that the door was locked to the resident lounge area failing to allow residents access to a common area.</p> <p>During an interview on 10/26/24, at 11:30 am the Nursing Home Administrator confirmed that the facility failed to provide a home like environment by failing to repair the leak in the ceiling of the bathroom for room [ROOM NUMBER], failing to permit residents access to common areas, and utilizing resident common areas and dining rooms for storage.</p> <p>PA Code: 201.29(k) Resident rights.</p> <p>PA Code: 207.2(a) Administrator's responsibility.</p>

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<p>F 0585</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 voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.</p> <p>36115</p> <p>Based on a review of facility policies, documents and resident and staff interviews, it was determined that the facility failed to properly complete the grievance process for two of two resident allegations regarding the misappropriation of the resident's personal property. (Resident R1 and R3).</p> <p>Findings include:</p> <p>A review of facility Grievances/Concerns policy dated 9/10/24, indicated that the facility implements a grievance process by creating a grievance form, documents steps taken to investigate the grievance, complies a summary of the findings or conclusions, confirms a decision of either confirmed or unconfirmed, documents corrective action taken and dates when the resolution was issued.</p> <p>During a review of facility grievance documents on 10/15/24, it was revealed that the facility created a grievance form on 7/26/24, as the result of Resident R1's allegation that the maintenance department threw away her glasses. The grievance form provided no documentation of the findings of the facility's investigation, a summary of the findings, a decision of confirmed or unconfirmed allegations, any corrective action taken and the date of the resolve of the grievance.</p> <p>During an interview on 10/15/24, at 11:00 a.m., Assistant Director of Nursing (ADON) Employee E3 confirmed that the facility failed to complete the investigation of Resident R1's allegation and to timely resolve the resident's grievance as required.</p> <p>During a review of Resident R3's progress notes it was revealed that during a care conference conducted by the facility on 8/8/24, Resident R3 stated that she was missing her teeth, cell phone and articles of clothing.</p> <p>During an interview on on 10/26/24, at 10:30 a.m., Resident R3 confirmed that the facility had failed to respond to her allegations regarding misappropriation of her personal property.</p> <p>During a review of the facility grievance log it was revealed that the facility failed to implement the grievance process by creating a grievance form and beginning an investigation into Resident R3's allegations.</p> <p>During an interview on 10/26/24, at 11:00 am the Nursing Home Administrator and Director of Nursing confirmed that the facility failed to properly implement the grievance process and resolve the allegations of misappropriation of Resident R1's and R3's personal property in a timely manner as required .</p> <p>PA Code: 201.18(e)(4) Management.</p>		

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<p>F 0623</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.</p> <p>36115</p> <p>Based on a review of facility documents, an audit conducted by the State Ombudsman Office and staff interviews, it was determined that the facility failed to notify the State Ombudsman office of residents transfers and discharges for 42 of 42 months (3/21, 4/21, 5/21, 6/21, 7/21, 8/21, 9/21, 10/21, 11/21, 12/21, 1/22, 2/22, 3/22, 4/22, 5/22, 6/22, 7/22, 8/22, 9/22, 10/22, 11/22, 12/22, 1/23, 2/23, 3/23, 4/23, 5/23, 6/23, 7/23, 8/23, 9/23, 10/23, 11/23, 12/23, 1/24, 2/24, 3/24, 5/24, 6/24, 7/24, 8/24 and 9/24) as required.</p> <p>Finding include:</p> <p>A request to review facility documents on 10/15/24, of the facility's compliance in notifying the State Ombudsman Office revealed that the facility failed to provide documented evidence of notifying the State Ombudsman Office of residents transfers and discharges for the time period of 3/21, through 9/24.</p> <p>A review of an audit conducted on 8/1/24, by the State Ombudsman Office revealed that the facility failed to notify the State Ombudsman Office of resident transfers and discharges since 2/10/21.</p> <p>During an interview on 10/15/24, at 1:00 pm the Nursing Home Administrator confirmed that the facility failed to report resident transfers and discharges to the State Ombudsman Office for 42 months from 3/21, through 9/24, as required</p> <p>PA Code: 201.29(f)(g) Resident rights.</p>		

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<p>F 0908</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Keep all essential equipment working safely.</p> <p>36115</p> <p>Based on observations and staff interviews it was determined that the facility failed to maintain in proper working order equipment used for two of two methods for visitors to gain entrance to the facility during off hours. (Intercom system and Telephone system)</p> <p>Findings include:</p> <p>During an observation on 10/26/24, at 9:18 a. m., which was a Saturday morning, it was revealed that the intercom system used to notify staff of a visitor requesting access to the facility was not functioning properly. It was revealed that the intercom located at the first floor nursing unit had been removed from the wall which left exposed wire hanging from the wall and the nursing staff the inability to respond to an activated intercom and the visitor to gain access to the facility.</p> <p>During an observation on 10/26/24, at 9:20 am it was revealed that the facility's telephone number when unanswered by staff would disconnect and failed to transfer the call to another telephone extension which created the inability for the visitor to gain access to the facility.</p> <p>During an interview on 10/26/24, at 11:00 am the Nursing Home Administrator and Director of Nursing confirmed that the facility failed to maintain two of two methods for visitor entrance to the facility is proper working order as required.</p> <p>PA Code: 207.2(a) Administrator's responsibility.</p>		