| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 396056 | A. Building<br>B. Wing | 06/06/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| William Penn Care Center | 2020 Ader Road<br>Jeannette, PA 15644 |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, clinical records, facility documents, and staff interviews, it was determined that the facility failed to provide adequate supervision resulting in an elopement (resident exits to an unsupervised or unauthorized area without the facility's knowledge) for one of four residents (Resident R44).<br><br>Findings include:<br><br>Review of facility policy Elopements and Wandering Residents dated 1/28/25, indicated the facility ensures that residents which exhibit wandering behaviors and/or are at risk for elopement receive adequate supervision to prevent accidents, and receive care in accordance with their person-centered plan of care addressing the unique factors contributing to wandering or elopement risk. Alarms are not a replacement for necessary supervision. Staff are to be vigilant in responding to alarms in a timely manner. The facility shall establish and utilize a systemic approach to monitoring and managing residents at risk for elopement or unsafe wandering, including identification and assessment of risk, evaluation and analysis of hazards and risks, implementing interventions to reduce hazards and risks, and monitoring for effectiveness and modifying interventions when necessary.<br><br>Review of the Resident Assessment Instrument 3.0 User's Manual effective October 2023, indicated that a Brief Interview for Mental Status (BIMS) is a screening test that aides in detecting cognitive impairment. The BIMS total score suggests the following distributions:<br><br>13-15: cognitively intact<br><br>8-12: moderately impaired<br><br>0-7: severe impairment<br><br>Review of the clinical record indicated Resident R44 was admitted to facility 3/6/19, readmitted [DATE].<br><br>Review of Resident R44's Minimum Data Set (MDS, periodic assessment of resident care needs) dated 4/1/25, included diagnoses of heart disease, chronic kidney disease, and diabetes (a metabolic disorder in which the body has high sugar levels for prolonged periods of time). Review of Section C: Cognitive Patterns, Questions C0500 BIMS Summary Score revealed Resident R44's score to be 12, moderate cognitive impairment.<br><br>(continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of Elopement/Wandering Risk 24 assessment dated [DATE], revealed Resident R44 was NOT at risk for elopement at this time, and NOT at safety risk for wandering at this time and/or wanders but is easily redirected.<br><br>Review of Elopement/Wandering Risk 24 assessment dated [DATE], revealed Resident R44 was NOT at risk for elopement at this time, and NOT at safety risk for wandering at this time and/or wanders but is easily redirected.<br><br>Review of Elopement/Wandering Risk 24 assessment dated [DATE], revealed Resident R44 was NOT at risk for elopement at this time, and NOT at safety risk for wandering at this time and/or wanders but is easily redirected.<br><br>Review of a progress note dated 5/11/25, at 11:41 p.m., indicated Registered Nurse received a call from a staff member stating that resident was out in the parking lot. Staff member was coming back inside after taking a break when she noticed resident driving his electric wheelchair in the parking lot. Upon going out to parking lot resident seen sitting in electric wheelchair with a pile of belongings in his lap. Resident exhibits some confusion. Resident was assisted back into building and into his room. Resident was assisted into bed per his request. Resident denies pain, no skin issues noted. Vital signs were within normal limits. Upon reentering building, front doors were noted to pushed open and off of the tracks. Alarm notes to not be going off. Upon questioning staff, no alarm was heard this evening. Alarm checked for functioning: not functioning. Doors were placed back on tracks and locked, maintenance notified of door alarm not functioning. 15 minute safety checks were initiated.<br><br>Review of facility submitted documents on 5/12/25, indicated On 5/11/2025 at 2141 (11:41 p.m.), resident was in his motorized wheelchair. He crashed the chair against the locked front lobby door causing the door to open. Staff responded and approached resident in the front of the building. Resident stated that he was trying to get out, but also stated that someone stole his wheelchair and that he was looking for the door to get in. Staff assisted resident back into the building. Resident had no overt injury, nor did he have complaints.<br><br>Review of an employee statement written by Licensed Practical Nurse (LPN) Employee E2 dated 5/11/25, indicated upon returning from gas station, resident (R44) was found sitting in his power wheelchair in the back parking lot. Employee E2 called the Nursing supervisor, and waited with resident until supervisor arrived. Resident was assisted back into building. Once inside, it was seen that resident had pushed the sliding doors off the hinge. Resident confirmed that is how he left.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 6/3/25, at 1:10 p.m., Registered Nurse (RN) Employee E3 stated that she was the shift supervisor on 5/11/25. RN Employee E3 stated that she received a call from a staff member returning from her break, that Resident R44 was outside in the parking lot where the employee park. RN Employee E3 further stated that when she arrived outside, she found Resident R44 in the parking lot with LPN Employee E2. Employee E3 stated that Resident R44 was confused, uninjured, and required to be manually pushed back into facility for his electric wheelchair had no more power. Employee E3 further stated that she walked past the front doors and found them open, off track, and ajar, with no alarm sounding. Employee E3 next stated that she realigned, closed and locked the front doors, and checked the alarm to find that it was not functioning properly. Employee E3 stated that she notified the Director of Nursing (DON) and maintenance regarding the event and her findings. RN Employee E3 then stated that she has known Resident R44 for a few years, and this behavior was new and unaware of any prior indications by resident to leave facility. Employee E3 then stated that she returned to Resident R44's room to further interview him shortly after event, and found that he had no recollection of going outside.<br><br>During an interview on 6/4/25, at 10:00 a.m., the Director of Nursing (DON) confirmed that the facility failed to provide adequate supervision resulting in an elopement for one of four residents (Resident R44) as reviewed.<br><br>28 Pa. Code 201.14(a) Responsibility of licensee.<br><br>28 Pa. Code 201.18(b)(1)(3) Management.<br><br>28 Pa. Code 211.12(d)(1)(3)(5) Nursing services. |

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| F 0692<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide enough food/fluids to maintain a resident's health.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of the facility policy, clinical record review and staff interview, it was determined that the facility failed to accurately assess the nutritional status, and failed to update an individualized care plan to address the resident's specific nutritional concerns for one of four residents (Resident R65) records reviewed.<br><br>Findings include:<br><br>Review of facility's policy Nutritional Assessment, dated 1/28/25, indicated part of the comprehensive assessment, a nutritional assessment, including current nutritional status and risk factors for impaired nutrition, shall be conducted for each resident. The dietitian, in conjunction with the nursing staff and healthcare practioners, will conduct a nutritional assessment for each resident upon admission (within current baseline assessment timeframes) and as indicated by a change in condition that places the resident at risk for impaired nutrition. As part of the comprehensive assessment, the nutritional assessment will be a systemic, multidisciplinary process that includes gathering and interpreting data and using that data to help define meaningful interventions for the residents at risk for or with impaired nutrition. Once current conditions and risk factors for impaired nutrition are assessed and analyzed, individual care plans will be developed that address or minimize to the extent possible the resident's risks for nutritional complications. Such interventions will be developed within the context of the resident's prognosis and personal preferences.<br><br>Review of the clinical record indicated Resident R65 was admitted to the facility on [DATE].<br><br>Review of Resident R65's Minimum Data Set (MDS - a periodic assessment of care needs) dated 3/4/25, indicated diagnoses of traumatic brain injury, aphasia (disorder that affects how you communicate due to brain damage), and heart disease. Section K0300 was coded a 2, which indicated that Resident R65 had a weight loss of 5% or more in the last month or weight loss of 10% or greater in the last six months.<br><br>Review of R65's medical record revealed a clinical Dietary - MDS Assessment note dated 3/8/25, that failed to identify parameters for significant weight loss, to include prior weights associated with identified loss, and specific time frames of the loss.<br><br>Review of current nutritional plan of care initiated 4/11/24, updated 3/13/25, failed to indicate a nutritional focus/concern, goals, and interventions to address Resident R65's significant weight loss as identified in MDS dated [DATE].<br><br>During an interview on 6/6/25, at 11:07 a.m., Certified Dietary Manager (CDM) Employee E1 confirmed that clinical Dietary - Assessment note dated 3/8/25, failed to address parameters for Resident R65's significant weight loss as identified in MDS dated [DATE].<br><br>During an interview on 6/6/25, at 11:53 a.m., the Director of Nursing (DON) confirmed facility failed to accurately assess the nutritional status, and failed to update an individualized care plan to address the resident's specific nutritional concerns for one of four residents (Resident R65) records reviewed.<br><br>(continued on next page) |

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| F 0692<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 28 Pa. Code: 201.18(b)(1)(e)(1) Management.<br><br>28 Pa. Code: 211.12(d)(5) Nursing services. |

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| F 0756<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, clinical records and staff interview, it was determined that the facility failed to provide documentation of medication regimen reviews (MRR) completed at least monthly for three of three sampled resident records (Resident R20, R59, R67).<br><br>Finding include:<br><br>The facility Medication regimen review policy dated 1/28/25, indicated that the drug regimen review of each resident is at least monthly by a licensed pharmacist and includes a review of the resident's medical chart. A medication regimen review (MRR) or drug regimen review, is a thorough evaluation of the medication regimen of a resident with the goal of promoting positive outcomes.<br><br>Review of Resident R20's admission record indicated she was admitted to the facility on [DATE].<br><br>Review of Resident R20's MDS assessment (MDS: Minimum Data Set assessment-a periodic assessment of resident care needs) dated 5/13/25, indicated she had diagnoses that included dementia (group of symptoms affecting memory, thinking, and social abilities that interfere with daily life), heart disease, and diabetes (a metabolic disorder impacting organ function related to glucose levels in the human body).<br><br>Review of Resident R20's care plan dated 4/14/22, indicated that pharmacy will review monthly as per protocol.<br><br>Review of Resident R20's clinical progress notes did not include a pharmacy notation or review by a licensed pharmacist for April 2025.<br><br>Review of Resident R20's medication regimen reviews did not indicate a review for April 2025.<br><br>Review of Resident R59's admission record indicated he was admitted on [DATE], and readmitted on [DATE].<br><br>Review of Resident R59's MDS assessment dated [DATE], indicated he had diagnoses that included chronic kidney disease (a loss of kidney function resulting in the swelling of feet, fatigue, high blood pressure and changes in urination), diabetes, and hyperlipidemia (elevated lipid levels within the blood).<br><br>Review of Resident R59's care plan dated 11/29/24, indicated that pharmacy will review monthly as per protocol.<br><br>Review of Resident R59's clinical progress notes did not include a pharmacy notation or review by a licensed pharmacist for April 2025.<br><br>Review of Resident R59's medication regimen reviews did not indicate a review for April 2025.<br><br>(continued on next page) |

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| F 0756<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Review of Resident R67's admission record indicated he was admitted on [DATE], and re-admitted on [DATE].<br><br>Review of Resident R67's MDS assessment dated [DATE], indicated he had diagnoses that included diabetes, emphysema (a chronic lung condition characterized by shortness of breath due to damage to the air sacs in the lung), hypertension (a condition impacting blood circulation through the heart related to poor pressure), and cirrhosis of the liver (damage to the liver causing nausea and fatigue).<br><br>Review of Resident R67's care plan dated 3/12/25, indicated that pharmacy will review monthly as per protocol.<br><br>Review of Resident R67's clinical progress notes did not include a pharmacy notation or review by a licensed pharmacist for April 2025.<br><br>Review of Resident R67's medication regimen reviews did not indicate a review for April 2025.<br><br>During an interview on 6/5/25, at 12:15 p.m. the Director of Nursing confirmed that the facility failed to provide documentation of medication regimen reviews (MRR) completed at least monthly for Residents R20, R59, and R67, as required.<br><br>28 Pa. Code: 201.14 (a) Responsibility of licensee.<br><br>28 Pa. Code 211.5(f) Medical records.<br><br>28 Pa. Code: 211.12(d)(1)(3)(5) Nursing services. |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>Based on a review of policy, observation and staff interview, it was determined that the facility failed to properly maintain kitchen equipment in a sanitary condition creating the potential for cross contamination in the main kitchen of the facility.<br><br>Findings include:<br><br>A review of facility policy Food Safety and Sanitation dated 1/28/25, indicated all local, state and federal standards and regulations will be followed in order to assure a safe and sanitary food and nutrition department.<br><br>During an observation on 6/2/25, at 10:00 a.m., of the walk-in cooler in the main kitchen, conducted with Certified Dietary Manager (CDM) Employee E1, revealed that the cold air condenser unit had a build-up of dust, grime, and dark colored debris around the fan covers and ceiling immediately forward of the fans. CDM Employee E1 confirmed observation by surveyor when viewed.<br><br>During an interview on 6/2/25, at 10:05 a.m., CDM Employee E1 confirmed that the facility failed to properly maintain kitchen equipment, walk-in cooler, in a sanitary condition creating the potential for cross contamination in the main kitchen of the facility.<br><br>28 Pa. Code: 201.14(a) Responsibility of licensee.<br><br>28 Pa. Code: 201.18(b)(1) Management. |