

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 12/04/2024
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 396067	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/15/2024
NAME OF PROVIDER OR SUPPLIER Concordia at Rebecca Residence		STREET ADDRESS, CITY, STATE, ZIP CODE 3746 Cedar Ridge Road Allison Park, PA 15101	
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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45577 Based on review of facility policy, resident grievances, resident, resident family member, and staff interviews, it was determined that the facility failed to record the nature and specifics of verbalized grievances related to resident clinical care concerns on the designated grievance form as required for one of three residents (Resident R29). Findings include: Review of the facility policy Resident and Family Grievances dated 4/1/24, indicated grievances may be voiced in the following forum - a verbal complaint to a staff member of Grievance Official, and the staff member receiving the grievance will record the nature and specifics of the grievance on the designated grievance form, or assist the resident or family member to complete the form. Review of the facility grievance logs from May 2024 - August 2024, indicated all documented grievances were in relation to missing personal property, and not related to clinical care concerns received by staff. Review of the admission record indicated Resident R29 admitted to the facility on [DATE]. Review of Resident R29's Minimum Data Set (MDS- a periodic assessment of care needs) dated 7/18/24, indicated the diagnoses of heart failure (heart doesn't pump blood as well as it should), peripheral vascular disease (a condition in which narrowed blood vessels reduce blood flow to the limbs), and atrial fibrillation (irregular heart rhythm). Review of Resident R29's progress note dated 8/6/24, indicated a meeting with Resident R29's family member who expressed issues they would like the interdisciplinary team to problem solve including: medications not being reordered timely, which resolved for a short time but continues to persist as a chronic issue, concerns with one medication that causes increased urination and a past request for resident to get changed every four hours is not happening, resident being told she rings the bell too frequently with needing to go to the bathroom, and resident's demeanor is turning into a feeling that she is a burden to others, timely cleaning of resident's room and bathroom, weight loss, meal choices being very repetitive and boring, lack of pudding to take her medications with, monthly weights, and resident's increased anxiety. (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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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 8/13/24, at 11:00 a.m. Resident R29 was in her room sitting in a chair and a family member was making her bed. Interview on 8/13/24, at 11:00 a.m. Resident R29 indicated I'm very hard of hearing. I'm frustrated. You never know what each day will bring. I put my light on and wait upwards of 30 - 45 minutes, they are messing up my pills. One day I put my light on at 4:00 p.m. and gave up on anyone answering it until 7:00 p.m. that evening. This hospice was supposed to run out in three to six months, and it's been a year and a half. I want it to be over. Interview on 8/13/24, at 11:02 a.m. Resident R29's family member indicated grave frustration with repeated concerns not being met and not enough facility staff. Indicated a conversation with management that indicated resident's room was last room in hallway and was out of sight, and out of mind. Repeated multiple concerns (as indicated in progress note date 8/6/24, above) without resolution and lack of empathy from staff. Interview on 8/15/24, at 9:30 a.m. the Director of Nursing confirmed clinical care concerns were not recorded on a grievance as required and that the facility failed to record the nature and specifics of verbalized grievances related to resident clinical care concerns on the designated grievance form as required for one of three residents (Resident R29). 28 Pa. Code 201.14(a) Responsibility of licensee. 28 Pa. Code 201.18(b)(1)(3)(e)(1) Management. 28 Pa. Code 211.10(d) Resident care policies. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services.		

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45577 Based on facility policy, clinical record review and staff interview, it was determined that the facility failed to make certain that the necessary resident information was communicated to the receiving health care provider for two of four residents with facility-initiated transfer (Residents R7 and R10). Findings include: Review of the facility policy Transfer and discharge date d 1/1/24, indicated all information necessary to meet the resident's needs for a transfer to another provider. Review of Resident R10's admission record indicated she was originally admitted on [DATE], with diagnoses that included dysphagia (difficulty or discomfort in swallowing), borderline personality disorder and major depressive disorder. Review of Resident R10's annual MDS assessment (MDS-Minimum Data Set assessment: periodic assessment of resident care needs) dated 6/6/24, indicated that the diagnoses were current upon review. Review of Resident R10's clinical record revealed that the resident was transferred to the hospital on 3/1/24, and returned to the facility on [DATE]. Review of Resident R10's clinical record revealed no documented evidence that the facility had communicated specific information to the receiving health care provider for the residents transferred and expected to return, which included the resident's care plan goals, advanced directive information, specific instructions for ongoing care, resident representative information, and all information necessary to meet the residents specific needs at the receiving facility Review of Resident R7's admission record indicated he was originally admitted on [DATE], with diagnoses that included osteomyelitis (a bone infection that causes inflammation and swelling in the bone), type 2 diabetes mellitus and cerebral palsy (group of neurological disorders that affect a person's ability to control their muscles and movement). Review of Resident R7's quarterly MDS assessment (MDS-Minimum Data Set assessment: periodic assessment of resident care needs) dated 6/26/24, indicated that the diagnoses were current upon review. Review of Resident R7's clinical record revealed that the resident was transferred to the hospital on 6/6/24, and returned to the facility on [DATE]. Review of Resident R7's clinical record revealed no documented evidence that the facility had communicated specific information to the receiving health care provider for the residents transferred and expected to return, which included the resident's care plan goals, advanced directive information, specific instructions for ongoing care, resident representative information, and all information necessary to meet the residents specific needs at the receiving facility. (continued on next page)		

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/15/24 at 11:05 a.m. the Director of Nursing (DON) confirmed that the facility failed to provide the necessary information for Resident R7 and R10. 28 Pa. Code 201.29(a)(c.3)(2) Resident rights.		

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45577 Based on facility policy, clinical record review and staff interview, it was determined that the facility failed to provide a transfer notice to a representative of the Office of the Long-Term Care Ombudsman Division for two of four residents (Residents R7 and R10). Findings include: Review of the facility policy Transfer and discharge date d 1/1/24, indicated all information necessary to meet the resident's needs for a transfer to another provider. Review of Resident R10's admission record indicated she was originally admitted on [DATE], with diagnoses that included dysphagia (difficulty or discomfort in swallowing), borderline personality disorder and major depressive disorder. Review of Resident R10's annual MDS assessment (MDS-Minimum Data Set assessment: periodic assessment of resident care needs) dated 6/6/24, indicated that the diagnoses were current upon review. Review of Resident R10's clinical record revealed that the resident was transferred to the hospital on 3/1/24, and returned to the facility on [DATE]. Review of Resident R10's clinical record indicated the facility failed to include documented evidence that the facility provided a written transportation notification to the Office of the Long-Term Care Ombudsman for the hospitalization on [DATE]. Review of Resident R7's admission record indicated he was originally admitted on [DATE], with diagnoses that included osteomyelitis (a bone infection that causes inflammation and swelling in the bone), type 2 diabetes mellitus and cerebral palsy (group of neurological disorders that affect a person's ability to control their muscles and movement). Review of Resident R7's quarterly MDS assessment (MDS-Minimum Data Set assessment: periodic assessment of resident care needs) dated 6/26/24, indicated that the diagnoses were current upon review. Review of Resident R7's clinical record revealed that the resident was transferred to the hospital on 6/6/24, and returned to the facility on [DATE]. Review of Resident R7's clinical record indicated the facility failed to include documented evidence that the facility provided a written transportation notification to the Office of the Long-Term Care Ombudsman for the hospitalization on [DATE]. During an interview on 8/15/24 at 11:05 a.m. the Director of Nursing (DON) confirmed the facility failed to provide a transfer notice to a representative of the Office of the Long-Term Care Ombudsman Division for two out of four residents (Residents R7 and R10). 28 Pa. Code 201.29(a)(c.3)(2) Resident rights.		

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45577 Based on facility policy, clinical record review and staff interview, it was determined that the facility failed to notify the resident or resident's representative of the facility bed-hold policy (an agreement for the facility to hold a bed for an agreed upon rate during a hospitalization) for two of four residents (Residents R7 and R10). Findings include: Review of the facility policy Transfer and discharge date d 1/1/24, indicated all information necessary to meet the resident's needs for a transfer to another provider. Review of Resident R10's admission record indicated she was originally admitted on [DATE], with diagnoses that included dysphagia (difficulty or discomfort in swallowing), borderline personality disorder and major depressive disorder. Review of Resident R10's annual MDS assessment (MDS-Minimum Data Set assessment: periodic assessment of resident care needs) dated 6/6/24, indicated that the diagnoses were current upon review. Review of Resident R10's clinical record revealed that the resident was transferred to the hospital on 3/1/24, and returned to the facility on [DATE]. Review of Resident R10's clinical record indicated the facility failed to include documented evidence that the resident or the representative were provided with written information about the facility's bed hold policy at the time of the transfer to the hospital on 3/1/24. Review of Resident R7's admission record indicated he was originally admitted on [DATE], with diagnoses that included osteomyelitis (a bone infection that causes inflammation and swelling in the bone), type 2 diabetes mellitus and cerebral palsy (group of neurological disorders that affect a person's ability to control their muscles and movement). Review of Resident R7's quarterly MDS assessment (MDS-Minimum Data Set assessment: periodic assessment of resident care needs) dated 6/26/24, indicated that the diagnoses were current upon review. Review of Resident R7's clinical record revealed that the resident was transferred to the hospital on 6/6/24, and returned to the facility on [DATE]. Review of Resident R7's clinical record indicated the facility failed to include documented evidence that the resident or the representative were provided with written information about the facility's bed hold policy at the time of the transfer to the hospital on 6/6/24. During an interview on 8/15/24 at 11:05 a.m. the Director of Nursing (DON) confirmed the facility failed to provide a transfer notice to a representative of the Office of the Long-Term Care Ombudsman Division for two out of four residents (Residents R7 and R10). (continued on next page)		

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	28 Pa. Code 201.29(b)(d)(j) Resident rights.		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45577 Based on review of facility policy, clinical record review, and staff interviews, it was determined that the facility failed to develop care plans that included instructions to provide person centered care for one of seven residents (Resident R45). Findings include: Review of the facility policy Care Plan Revisions Upon Status Change, dated 4/1/24, indicated the comprehensive care plan will be reviewed, and revised as necessary, when a resident experiences a status change. Review of the admission record indicated Resident R45 admitted to the facility on [DATE]. Review of Resident R45's Minimum Data Set (MDS - a periodic assessment of care needs) dated 7/11/24, indicated the diagnoses of Non Alzheimer's Dementia (dementia caused by other diseases with symptoms forgetfulness, limited social skills, and impaired thinking abilities that interfere with daily functioning), high blood pressure, and diabetes (a long-term condition in which the body has trouble controlling blood sugar and using it for energy). Review of Resident R45's physician order dated 6/1/24, indicated check wander guard (a bracelet that alerts staff when a resident travels beyond a supervised and authorized area), for proper functioning every shift. Location left wrist. Review of Resident R45's care plan dated 8/13/24, failed to include a plan of care for behaviors, wandering, wander guard placement, and or elopement prevention. Observation on 8/15/24, at 10:00 a.m. Resident R45 was observed in his room with a wander guard bracelet on the left wrist. Interview on 8/15/24, at 10:01 a.m. Registered Nurse (RN) Employee E3 confirmed Resident R45 had a wander guard, and it would alert staff if he left a safe area. Interview on 8/15/24, at 11:55 a.m. Registered Nurse Assessment Coordinator (RNAC) Employee E2 confirmed Resident R45's care plan failed to include a plan of care for behaviors, wandering, wander guard placement, and or elopement prevention. Interview on 8/16/24, at 2:00 p.m., the Director of Nursing confirmed the facility failed to develop care plans that included instructions to provide person centered care for one of seven residents (Resident R45). 28 Pa. Code 211.10(d) Resident care policies. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services.		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45577 Based on observation, clinical record review, and staff interview, it was determined that the facility failed to follow physician orders for weights four out of six residents (Resident R10, R26, R29, and R207). Findings include: Interview with the Director of Nursing on 8/15/24, at 11:00 a.m. indicated the facility did not have a policy relating to physician orders. Review of Resident R10's admission record indicated she was originally admitted on [DATE], with diagnoses that included dysphagia (difficulty or discomfort in swallowing), borderline personality disorder and major depressive disorder. Review of Resident R10's annual MDS assessment (MDS-Minimum Data Set assessment: periodic assessment of resident care needs) dated 6/6/24, indicated that the diagnoses were current upon review. Review of Resident R10's physician order's last reviewed 8/14/24, indicated to weigh Daily x 1 day for monthly weight - no weight obtained x3 months. Review of Resident R10's weight and vitals summary revealed the last weight obtained was 3/13/24. Review of Resident R26's admission record indicated an admitted [DATE], with diagnoses that include lung cancer, brain cancer, and respiratory failure (syndrome in which the respiratory system fails on one or both of its gas exchange function: oxygenation and carbon dioxide elimination). Review of Resident R26's MDS dated [DATE], indicated that the diagnoses were current upon review. Review of Resident R26's physician orders last reviewed 8/15/24, indicated daily weight dx (diagnosis) CHF (Congestive heart failure - heart doesn't pump blood as well as it should) every day shift. Review of Resident R26's weight and vitals summary revealed the last weight obtained was 8/4/24. Review of Resident R29's admission record indicated original admitted as 4/10/24, with diagnoses that included heart failure, peripheral vascular disease (a condition in which narrowed blood vessels reduce blood flow to the limbs), and atrial fibrillation (irregular heart rhythm). Review of Resident R29's MDS dated [DATE], indicated that the diagnoses were current upon review. Review of Resident R29's physician orders last reviewed 8/13/24, indicated to weigh resident monthly. Review of Resident R29's weight and vitals summary revealed the last weight obtained was 6/17/24. (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident R207's admission record indicated original admitted as 8/6/24, with diagnoses that included obstructive uropathy (hindrance of normal urine flow), cardiomyopathy (disease of the heart muscle), and compression fracture of spine (a break in the bones that make up the spine). Review of Resident R207's Diagnoses Report dated 8/14/24, indicated the diagnoses were current upon review. Review of Resident R207's physician orders dated 8/6/24, indicated weigh weekly for four weeks. Review of Resident R207's weight and vitals summary revealed no weights recorded. During an interview on 8/15/24, at 11:05 a.m., the Director of Nursing (DON) confirmed that the facility failed to follow physician orders for four of six residents (Resident R10, R26, R29, and R207). 28 Pa. Code: 211.10(c)(d) Resident care policies. 28 Pa. Code: 211.12(d)(1)(2)(3)(5) Nursing services		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45577 Based on review of facility policy, national accepted guidelines for Pressure Ulcers, and staff interview, it was determined that the facility failed to accurately assess pressure ulcers for two of residents (Resident R35 & R37). Findings include: The facility policy entitled Pressure Injury Prevention and Management last reviewed 1/1/24, indicated licensed nurses will conduct a full body assessment upon admission, findings will be documented in the medical record. The staging of pressure injuries will be clearly identified Review of the clinical record indicated Resident R35 was admitted to the facility on [DATE]. Review of the Minimum Data Set (MDS - periodic assessment of care needs) dated 7/25/24, indicated that Resident R35 had diagnoses that included urinary tract infection, muscle wasting and edema. Review of the clinical admission assessment dated [DATE], indicated that Resident R35 has a pressure ulcer on buttocks, no measurements. Further review of Resident R35's clinical record from 7/18/24 through 7/29/24, revealed no measurement. Review of the clinical record indicated Resident R37 was admitted to the facility on [DATE]. Review of the Minimum Data Set (MDS - periodic assessment of care needs) dated 7/13/24, indicated that Resident R37 had diagnoses osteoarthritis, muscle wasting and major depressive disorder. Review of the clinical admission assessment dated [DATE], indicated that Resident R37 has a bruising. Further review of Resident R37's clinical record from revealed no measurement until 7/9/24 and resident had pressure ulcer upon admission. During an interview on 8/14/24, at 11:15 a.m. the Director of Nursing confirmed the facility failed to accurately assess pressure ulcers for two of five residents. 28 Pa. Code: 211.12(d)(1)(5) Nursing services		

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 45577 Based on review of facility policy, clinical records, and staff interview, it was determined that the facility failed to obtain a physician order for type and care of a supra-pubic catheter (a hollow flexible tube that is used to drain urine from the bladder that is inserted into the bladder through a cut in the abdomen) for one of three residents (Resident R207). Findings include: Review of the facility policy Indwelling Catheter Use and Removal dated 4/1/24, indicated the facility will provide appropriate care for the catheter in accordance with professional standards of practice and care policies and procedures that include identification and documentation of clinical indications for use of the catheter, insertion, and ongoing care. Review of Resident R207's admission record indicated original admitted as 8/6/24, with diagnoses that included obstructive uropathy (hindrance of normal urine flow), cardiomyopathy (disease of the heart muscle), and compression fracture of spine (a break in the bones that make up the spine). Review of Resident R207's Diagnoses Report dated 8/14/24, indicated the diagnoses were current upon review. Review of Resident R207's physician order dated 8/6/24, indicated foley catheter care - nurse aide to provide foley catheter care every shift. Further review of Resident R207's physician orders on 8/13/24, failed to include a physician order specifying type of foley catheter, size, when to change catheter, and the reason for catheter use. Review of Resident R207's care plan dated 8/7/24, indicated supra pubic catheter every shift. Staff will keep drainage bag off of floor. Observation on 8/13/24, at 10:21 a.m. Resident R207 was observed in therapy gym with his catheter connected under his wheelchair, uncovered, and touching the floor. Interview on 8/13/24, at 10:22 a.m. Registered Nurse (RN) Employee E3 confirmed the catheter bag should not be touching the floor and should have a cover over the bag as required for resident dignity. Interview on 8/16/24, at 2:00 p.m. the Director of Nursing confirmed that the facility failed to obtain physician order for type and care of a supra-pubic catheter for one of three residents (Resident R207). 28 Pa. Code 211.10(d) Resident care policies. 28 Pa. Code: 211.12(d)(1)(2)(3)(5) Nursing services.		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45577 Based a review of facility policy, clinical record review and staff interview, it was determined that the facility failed to make certain that nutritional supplement intakes were documented accurately for two of five residents (Resident R18 and R26), failed to develop an individualized care plan to address the residents' specific nutritional interventions for one of five residents (Resident R18), and failed to complete a comprehensive nutritional assessment due to status change for one of five residents (Resident R26). Findings include: Review of facility policy Nutritional Management, dated 4/1/24, indicated that the facility provides care and services to each resident to ensure the resident maintains acceptable parameters of nutritional status in the context of his or her overall condition. A comprehensive nutritional assessment will be completed by a dietitian within 72 hours of admission, annually, and upon significant change in condition. The resident's goals and preferences regarding nutrition will be reflected in the resident's plan of care. Review of facility policy Nutritional and Dietary Supplement, dated 4/1/24, indicated that nutritional and dietary supplements will be used to compliment a resident's dietary needs in order to maintain adequate nutritional status and resident's highest practicable level of well-being. Resident's nutritional status will be accurately and consistently assessed upon admission and on as as needed basis to identify a residents nutritional risk and address risk factors for impaired nutritional status. The facility will provide nutritional and dietary supplements to each resident, consistent with the resident's assessed needs. Dietary supplements that are given between meals and contain vitamin(s) as one or more of its ingredients should be documented and evaluated as a dietary supplement, rather than a medication. The care plan will be updated with the new or modified nutritional intervention. Review of Resident R18's clinical record indicated that she was admitted to the facility 5/28/24. Review of Resident R18's Minimum Data Set (MDS - a periodic assessment of care needs) dated 6/4/24, indicated diagnoses of cerebral infarction (pathologic process that results in an area of necrotic tissue in the brain), aphasia (language disorder that results from damage to the left hemisphere of the brain), and dysphagia (difficulty swallowing). Review of Resident R18's current physician orders on 8/15/24, indicated that a high calorie liquid supplement three times a day for 4 oz (ounces) x (times) TID (three times a day), document % (percentage) consumed was ordered. Review of Resident R18's Medication Administration Record (MAR) for August 2024, failed to indicate that the percentage of the high calorie liquid supplement three times a day was documented per physician order. Review of Resident R18's current nutritional plan of care, initiated 5/31/24, revised on 6/24/24, failed to indicate, as an intervention, the use of the high calorie liquid supplement. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 396067	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/15/2024
NAME OF PROVIDER OR SUPPLIER Concordia at Rebecca Residence		STREET ADDRESS, CITY, STATE, ZIP CODE 3746 Cedar Ridge Road Allison Park, PA 15101	
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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/15/24, at 9:00 a.m., the Director of Nursing (DON) confirmed that Resident R18's MAR did not accurately document the percentage of consumption for the high calorie liquid supplement. During an interview of 8/15/24, at 10:00 a.m., the Registered Nurse Assessment Coordinator (RNAC) Employee E2 confirmed that the current care plan did not address the specific nutritional intervention for high calorie liquid supplement for Resident R18. Review of Resident R26's clinical record indicated that he was admitted to the facility 5/7/24. Review of Resident R26's MDS dated [DATE], indicated diagnoses that include lung cancer, brain cancer, and respiratory failure (syndrome in which the respiratory system fails on one or both of its gas exchange function: oxygenation and carbon dioxide elimination). Review of Resident R26's current physician orders on 8/15/24, indicated that a active liquid protein two times a day 30cc (milliliters) x (times) BID (twice a day), document % (percentage) consumed was ordered. Review of Resident R26's MAR for August 2024, failed to indicate that the percentage of the active liquid protein twice a day was documented per physician order. During an interview on 8/15/24, at 10:00 a.m., the Director of Nursing (DON) confirmed that Resident R26's MAR did not accurately document the percentage of consumption for the active liquid protein. Review of Resident R26's clinical record indicated that a Significant Change MDS was completed on 7/19/24. Further review of the clinical record failed to indicate that a comprehensive nutritional assessment was completed to assess the significant change in status identified by Resident R26's MDS dated [DATE]. During an interview on 8/15/24, at 11:09 a.m., RNAC Employee E2 confirmed that the facility failed to complete a comprehensive significant change nutritional assessment for Resident R26's MDS dated [DATE]. 28 Pa. Code: 201.18(b)(1)(e)(1) Management. 28 Pa. Code: 211.12(d)(1)(3)(5) Nursing services.		

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NAME OF PROVIDER OR SUPPLIER Concordia at Rebecca Residence		STREET ADDRESS, CITY, STATE, ZIP CODE 3746 Cedar Ridge Road Allison Park, PA 15101	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 45577 Based on observations and staff interview, it was determined that the facility failed to properly maintain sanitary conditions in the dish in the main kitchen which created the potential for cross contamination. Findings include: During an observation of the main designated kitchen on 8/13/24, at 9:05 a.m. the following was observed: - brown debris in ice machine During an interview on 8/13/24, at 9:10 a.m. Assistant Dietary General Manager Employee E1 confirmed the debris in ice machine. Employee E1 could not confirm the last time it was cleaned. During an interview on 8/13/24, at 9:15 a.m., Assistant General Manager Employee E1 confirmed that the facility failed to maintain sanitary conditions in the main kitchen which created the potential for food borne illness. 28 Pa. Code: 201.18(b)(1) Management. 28 Pa. Code: 211.6(c) Dietary services. 28 Pa. Code: 201.14(a) Responsibility of licensee.		

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NAME OF PROVIDER OR SUPPLIER Concordia at Rebecca Residence		STREET ADDRESS, CITY, STATE, ZIP CODE 3746 Cedar Ridge Road Allison Park, PA 15101	
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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45577 Based on facility policy, clinical record review, observation, and staff interview, it was determined the facility failed to implement measures to prevent the potential for cross contamination during a wound dressing change for one of three residents (Resident R42) and failed to maintain designated dressing change intervals for one of three residents with a (PICC) peripherally inserted central catheter (Resident R17). Findings include: Interview with the Director of Nursing on 8/14/24, at 11:00 a.m. indicated the facility does not have a policy for wound dressing changes. Review of facility provided procedure dated July 2024, indicated that a peripherally inserted central catheter's (PICC) transparent dressing should be changed at least every seven days and when the dressing is not intact, the dressing is loose or moist, and when drainage or blood is under the dressing. Review of the clinical record indicated Resident R42 was admitted to the facility on [DATE]. Review of Resident R42's Minimum Data Set (MDS - a periodic assessment of care needs) dated 8/2/24, indicated diagnoses of high blood pressure, fibromyalgia (a long-term condition that involves widespread body pain and tiredness), and cellulitis (a serious bacterial skin infection). Review of Resident R42's physician order dated 8/9/24, indicated to cleanse right shin with 0.125% Dakins solution (a topical antiseptic). Apply medical grade honey (wound treatment), Hydrofera blue (a dressing that pulls harmful bacteria away from the wound bed) to the base of the wound. Secure with abdominal pad (large absorbent sponge), rolled gauze and ACE wraps from toes to knees every other day. Observation of Resident R42's dressing change on 8/14/24, at 10:40 a.m. Registered Nurse (RN) Employee E3 took the entire bottle of Dakins 0.125% solution, and the entire box, and tube of medical grade honey into the resident's room and on the bedside table. Interview on 8/14/24, at 11:00 a.m. RN Employee E3 confirmed the multi-use supplies of Dakins solution and medical grade honey were taken into the resident room, placed on the bedside table and therefore; considered contaminated and no longer appropriate to store in the treatment cart. Review of the clinical record indicated Resident R17 was admitted to the facility on [DATE]. Review of Resident R17's MDS dated [DATE], indicated the diagnoses of osteomyelitis (inflammation of bone caused by infection) of left ankle and foot, renal insufficiency (condition where the kidneys lose the ability to remove waste and balance fluids), and atrial fibrillation (irregular heart rhythm). (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Concordia at Rebecca Residence		STREET ADDRESS, CITY, STATE, ZIP CODE 3746 Cedar Ridge Road Allison Park, PA 15101	
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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R17's physician order dated 7/19/24, indicated to change IV (intravenous) dressing every seven days. Review of Resident R17's care plan dated 7/24/24, indicated at risk for infection related to IV-PICC. Catheter care as ordered. Observation of Resident R17 on 8/13/24, at 11:34 a.m. indicated a PICC line in the right upper arm covered with a transparent (clear) dressing with blood underneath it and dated 8/5/24. Interview 8/13/24, at 11:34 a.m. with Registered Nurse (RN) Employee E3 confirmed the date was 8/5/24, and that the dressing was not changed at the designated changing interval of every seven days. Interview on 8/14/24, at 1:40 p.m. the Director of Nursing confirmed the facility failed to implement measures to prevent the potential for cross contamination during a wound dressing change for one of three residents (Resident R42) and failed to maintain designated dressing change intervals for one of three residents with a PICC line (Resident R17). 28 Pa. Code: 201.14(a) Responsibility of licensee. 28 Pa. Code: 201.18(b)(1)(e)(1) Management. 28 Pa. Code: 201.20(c) Staff development. 28 Pa. Code: 211.10(d) Resident care policies. 28 Pa. Code: 211.12(d)(1)(2)(3)(5) Nursing services.		