

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

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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 03/13/2025
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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46336 Based on review of facility policy, observations and staff interviews it was determined that the facility failed to provide a clean, safe, comfortable, and homelike environment for three of twelve resident rooms (Residents R6, R19, and R159). Findings include: Review of the facility policy Resident Rights reviewed 4/1/24, indicated the resident has a right to a safe, clean, comfortable and homelike environment including but not limited to receiving treatment and supports for daily living safely. Review of the admission record indicated Resident R6 admitted to the facility on [DATE]. Observation on 3/10/25, at 9:34 a.m. Resident R6 was in the electric wheelchair in his room. The foot board of the bed's right side had the corner broken with the particle board halfway off exposing rough, irregular shapes at the perimeter of the board. The perimeter of the resident room walls, just above the baseboards, were gouged deeply and under the wall vent was actually separated from the wall. Interview with Resident R6 on 3/10/25, at 9:35 a.m. indicated he was unsure how long it's been broken. Review of the admission record indicated Resident R19 was admitted to the facility on [DATE]. Observation of Resident R19's room on 3/10/25, at 9:40 a.m. indicated a vertical wall vent with multiple louver slats damaged. Review of the admission record indicated Resident R159 was admitted to the facility on [DATE]. Observation of Resident R159's room on 3/10/25, at 9:45 a.m. indicated a vertical wall vent with multiple louver slats damaged. Interview and tour with Registered Nurse (RN) Employee E1 on 3/10/25, at 9:50 a.m. confirmed the observations for Resident R6, Resident R19, and Resident R159, and that there were damaged environments. (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: Facility ID: 396067	If continuation sheet Page 1 of 11

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 3/10/25, at 12:00 p.m. the Director of Nursing confirmed the facility failed to provide a clean, comfortable homelike environment for three of twelve resident rooms (Residents R6, R19, and R159). 28 Pa. Code: 201.14(a) Responsibility of licensee. 28 Pa. Code: 201.18(b)(1)(3) Management.		

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46336 Based on review of facility policies, facility provided documents, clinical records and staff interviews, it was determined that the facility failed to make certain a resident was free from neglect for one of three residents reviewed (Resident R1). Findings include: The facility's policy Abuse Neglect, and Exploitation policy reviewed 4/1/24, indicated it is the facility's policy to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property. Neglect means failure of the facility, its employees, or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. Review of admission record indicated Resident R1 was admitted to the facility on [DATE]. Review of Resident R1's Minimum Data Set (MDS - a periodic assessment of care needs) dated 1/28/25, indicated the diagnoses of congestive heart failure (heart doesn't pump blood as well as it should), high blood pressure, and cellulitis (a bacterial skin infection that affects the middle layer of the skin and underlying tissues) of right lower leg. Section C indicated a BIMS score of 14 (Brief Interview for Mental Status - a screening test that aides in detecting cognitive impairment). A total score of 13-15, indicated cognitively intact. Review of facility provided documents dated 2/1/25, indicated Resident R1 reported Nurse Aide (NA) Employee E2 refused to help her out of bed and just watched her while she struggled to get her right leg out of the bed, without help which caused pain. In the bathroom the staff member poured water over her head without telling her and roughly scrubbed her hair. While on the toilet staff member refused to help her get off the raised toilet seat and watched her try to get herself up for five to 10 minutes while insisting that she needed to do it on her own. Review of Resident R1's signed witness statement dated 2/3/25, indicated NA Employee E2 poked and laughed at her belly while on the toilet. After wiping her face with a washcloth, without telling or explaining what she was going to do, dumped soapy shampoo water on top of her head, and started to roughly scrub her head, then viciously brushed her hair. Staff member refused to help get resident out of bed. Resident's entire right leg was in severe pain and lifting it was extremely painful. NA Employee E2 did not wait for the larger toilet seat, the regular one was too small for resident's hips. NA Employee E2 wouldn't help try to get it over residents hips for some time. Finally got powder to try to ease it off, but it didn't work. Finally, the aide pushed all the hip tissue through. It was a very painful ordeal. Resident tried a long time without assistance and NA Employee E2 just stood there. Review of NA Employee E2's Witness Statement, not dated, indicated I had Resident R1 on Saturday. I took her to the bathroom a couple of times. I told her I'd give her privacy and to ring. She rang. I cleaned her from behind. Her foot is inflamed, so I tried being as gentle as I could. (continued on next page)		

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of facility investigation dated 2/6/25, at 3:03 p.m. indicated the facility's conclusion that NA Employee E2 was found to be negligent in care practices and was terminated from her position. Interview on 3/12/25, at 9:30 a.m. the Director of Nursing confirmed that the facility failed to make certain a resident was free from abuse and neglect for one of three residents reviewed (Resident R1). 28 Pa. Code 201.14(a) Responsibility of licensee. 28 Pa. Code 201.18(b)(1)(3) 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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46336 Based on review of facility policy, clinical record review, and staff interview, it was determined that the facility failed to ensure that a baseline care plan, that included the minimum healthcare information necessary to properly care for a resident was fully developed and implemented for two of seven residents (Residents R154 and R155). Findings include: Review of Code of Federal Regulations (CFR) S483.21(a) Baseline Care Plans S483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. S483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. Review of Resident R154's clinical record indicates an admitted [DATE]. (continued on next page)		

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident R154's Provider Note dated 3/7/25, indicated the diagnosis of left Tri malleolar fracture (a rare but serious ankle injury that involves simultaneous breaks in the three bones of the ankle), osteoarthritis (flexible tissue at the ends of bone wears down), and high blood pressure. Review of Resident 154's physician order dated 3/6/25, indicated Rivaroxaban 20 mg (milligrams) (an anticoagulant - blood thinning medication) give once daily in the evening for blood clots. Review of Residents R154's baseline care plan for the admitted [DATE], failed to include anticoagulant care. Review of Resident R155's clinical record indicated an admitted [DATE]. Review of Resident R155's physician orders dated 3/5/25, indicated the diagnosis of Parkinson's Disease (disorder of the nervous system that results in tremors), obstructive sleep apnea (a chronic condition in which the throat muscles relax during sleep and the airway may become partially or fully blocked), and sepsis (a life-threatening complication of an infection). Further review of Resident R155's physician orders dated 3/5/25, indicated the following: -Device type: Right upper extremity PICC line (peripherally inserted central catheter) every shift. -JP drain (Jackson Pratt a closed -suction medical device used after surgery to collect excess fluid from the surgical site, promoting healing and reducing the risk of infection) empty drain, record amount and characteristics of drainage every shift. Observation of Resident R155 on 3/10/25, at 9:20 a.m. indicated a left shoulder surgical site with JP drain and gauze dressing. Review of Resident R155's baseline care plan for the admitted [DATE], failed to include PICC line care, JP drain care, or surgical site care. Interview on 3/11/25, at 1:17p.m. the Director of Nursing confirmed that the facility failed to ensure that a baseline care plan, that included the minimum healthcare information necessary to properly care for a resident was fully developed and implemented for two of seven residents (Residents R154 and R155). 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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46336 Based on review of facility policy, clinical records, and staff interview, it was determined the facility failed to update care plans to be reflective of residents' current needs for two of seven residents (Residents R10 and R33). Findings include: Review of the Code of Federal Regulations (CFR) S483.21(b) Comprehensive Care Plans: S483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. Review of the Admission Record indicated Resident R10 was admitted to the facility on [DATE]. Review of Resident R10's Minimum Data Set (MDS - a periodic assessment of care needs) dated 2/11/25, indicated the diagnoses of osteomyelitis (inflammation of bone caused by infection) left ankle and foot, atrial fibrillation (irregular heart rhythm), and heart failure (heart doesn't pump blood as well as it should), and presence of a pacemaker (a small device used to treat arrhythmias that sends electrical pulses to help the heart beat at normal rate and rhythm). Review of Resident R10's care plan dated 2/17/25, failed to indicate a plan for care and management of the pacemaker. (continued on next page)		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 3/11/25, at 1:17 p.m. the Assistant Director of Nursing Employee E6 confirmed the facility failed to update care plans to be reflective of residents' current needs and that a plan for the care and management of the pacemaker was not completed for Resident R10. Review of Admission Record indicated Resident R33 was admitted to the facility on [DATE]. Review of Resident R33's Minimum Data Set (MDS - a periodic assessment of care needs) dated 1/28/25, indicated the diagnoses of cerebral infarction (also known as a stroke, occurs when blood flow to the brain is disrupted due to issues with the arteries that supply it), dysphagia (difficulty swallowing solids and liquids), and heart disease. Review of Resident R33's clinical nutrition progress note dated 2/28/25, indicated nutrition interventions were reviewed for skin integrity; 2/24/25 weight reflects a 13% weight loss (significant weight loss) in six months; stage 3 sacral wound is healing. Review of Resident R33's current Nutrition: Potential for altered Nutrition status plan of care, initiated 10/7/22, updated 3/10/25, failed to identify focused nutritional problems, goals, and interventions specific to significant weight loss, and sacral wound. During an interview on 3/12/25, at 9:57 a.m., Registered Nurse Assessment Coordinator (RNAC) Employee E3 confirmed that Resident R33's care plan failed to be updated and identify focused nutritional problems, goals, and interventions specific to resident's current nutritional status. During an interview on 3/13/25, at 11:15 a.m., the Nursing Home Administrator (NHA) and Director of Nursing (DON) confirmed that the facility failed to update care plans to be reflective of residents' current needs for two of seven residents (Residents R10 and R33). 28 Pa. Code: 211.10(c) Resident care policies. 28 Pa. Code: 211.12(d)(1)(5) Nursing services.		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46336 Based on review of facility policy, observations, staff interviews, and clinical record review, it was determined that the facility failed to provide appropriate respiratory care related to oxygen equipment and CPAP/BIPAP (a continuous positive airway pressure machine used to keep airways open while you sleep/a bi-level positive airway pressure machine when breathing in and breathing out) management for four of six residents (Residents R10, R154, R155, and R156). Findings include: Review of the facility policy Oxygen Concentrator reviewed 4/1/24, indicated an oxygen concentrator is a medical device that extracts oxygen from room air by filtering out or separating the nitrogen from the oxygen. The oxygen passes through a filter system and is then stored within the device for delivery based on the flow meter setting. Review of the facility policy Noninvasive Ventilation reviewed 4/1/24, indicated the facility will obtain an order for the use of a CPAP/BIPAP device and settings from the practitioner. Review of the Admission Record indicated Resident R10 was admitted to the facility on [DATE]. Review of Resident R10's Minimum Data Set (MDS - a periodic assessment of care needs) dated 2/11/25, indicated the diagnoses of osteomyelitis (inflammation of bone caused by infection) left ankle and foot, atrial fibrillation (irregular heart rhythm), and heart failure (heart doesn't pump blood as well as it should). Review of Resident R10's physician order dated 2/4/25, indicated Ipratropium-Albuterol Solution (a liquid medication that is aerosolized with a nebulizer to create a mist that is inhaled to help breathing) 3mls (milliliters) every four hours as needed for wheezing. Review of Resident R10s Medication Administration Record (MAR) dated March 2025, indicated the last dose of Ipratropium-Albuterol was received on 3/7/25. Review of Resident R10's care plan dated 2/17/25, indicated resident will receive medications as ordered. Observation on 3/10/25, at 9:30 a.m. Resident R10 was in room. On the bedside stand was a nebulizer mask, with no date and not in a bag as required. Interview and tour on 3/10/25, at 1:35 p.m. Registered Nurse (RN) Employee E1 confirmed the nebulizer was on bedside stand, not dated and bagged as required. Review of Resident R154's clinical record indicates an admitted [DATE]. Review of Resident R154's Provider Note dated 3/7/25, indicated the diagnosis of left Tri malleolar fracture (a rare but serious ankle injury that involves simultaneous breaks in the three bones of the ankle), osteoarthritis (flexible tissue at the ends of bone wears down), and high blood pressure. (continued on next page)		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident R154's physician orders dated 3/6/25, failed to include orders for CPAP/BIPAP use and management. Review of Resident R154's care plan failed to include a plan for CPAP/BIPAP use and management. Observation on 3/10/25, at 9:40 a.m. Resident R154 was in room. On the bedside stand was a CPAP/BIPAP device. Interview with Resident R154 on 3/10/25, at 9:40 a.m. indicated resident wears the device at night while she sleeps. Interview and tour on 3/10/25, at 1:35 p.m. Registered Nurse (RN) Employee E1 confirmed the CPAP/BIPAP device was on the bedside. Interview on 3/10/25, at 1:45p.m. Licensed Practical Nurse Assessment Coordinator (LPNAC) Employee E7 confirmed Resident R154's clinical record failed to have physician orders and/or a plan of care for CPAP/BIPAP use and management. Review of Resident R155's clinical record indicated an admitted [DATE]. Review of Resident R155's physician orders dated 3/5/25, indicated the diagnosis of Parkinson ' s Disease (disorder of the nervous system that results in tremors), obstructive sleep apnea (a chronic condition in which the throat muscles relax during sleep and the airway may become partially or fully blocked), and sepsis (a life-threatening complication of an infection). Further review of Resident R155's physician orders dated 3/5/25, failed to include orders for CPAP/BIPAP use and management. Review of Resident R155's care plan failed to include a plan for CPAP/BIPAP use and management. Observation of Resident R155 on 3/10/25, at 9:20 a.m. indicated a CPAP/BIPAP device on the bedside stand. Interview and tour on 3/10/25, at 1:40 p.m. Registered Nurse (RN) Employee E1 confirmed the CPAP/BIPAP device was on the bedside. Interview on 3/11/25, at 1:17p.m. the Director of Nursing confirmed Resident R155's clinical record failed to have physician orders and/or a plan of care for CPAP/BIPAP use and management. Review of the admission record indicated Resident R156 was admitted to the facility on [DATE]. Review of Resident R156's face sheet indicated the diagnoses of respiratory failure (a serious condition that makes it difficult to breathe on your own), chronic obstructive pulmonary disease (COPD- a group of diseases that block airflow and make it hard to breathe), and diabetes (a long-term condition in which the body has trouble controlling blood sugar and using it for energy). Review of Resident R156's physician orders dated 2/26/25, indicated night nurse to check every week, if oxygen used, to make sure filter is cleaned and oxygen tubing and humidifier has been changed. (continued on next page)		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident R156's care plan dated 3/5/25, indicated the resident has oxygen therapy related to COPD. Observation on 3/10/25, at 9:31 a.m. Resident R156 was in her room with the oxygen cannula in her nose and concentrator running. The concentrator failed to have a filter on either side of the machine as required. Interview and tour on 3/10/25, at 1:42 p.m. Registered Nurse (RN) Employee E1 confirmed the concentrator failed to have a filter on either side of the machine as required. Interview on 3/11/25, at 2:30 p.m. the Director of Nursing confirmed the facility failed to provide appropriate respiratory care related to oxygen equipment and CPAP/BIPAP management for four of six residents (Residents R10, R154, R155, and R156). 28 Pa. Code 201.14(a) Responsibility of licensee. 28 Pa. Code 201.18(b)(1)(3) Management. 28 Pa. Code 211.10(d) Resident care policies. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services.		