STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395011	A. BLDG: 00 B. WING:	12/19/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
PLATINUM RIDGE CENTER FOR REHABILITATION AND HEALING STATE LICENSE NUMBER: **070302**	**1050 BROADVIEW BOULEVARD BRACKENRIDGE, PA 15014**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0000	INITIAL COMMENT Based on an abbreviated survey in response to a two complaint's completed on December 19, 2024, it was determined that Platinum Ridge Center for Rehab and Healing was not in compliance with the following requirements of 42 CFR Part 483, Subpart B Requirements for Long Term Care Facilities and the 28 PA Code, Commonwealth of Pennsylvania Long Term Care Licensure Regulations.	F 0000		
F 0620 SS=D		F 0620		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: | (X6) DATE:

Any deficiency statement ending with an asterisk (*) denotes a deficiency which may be excused from correction providing it is determined that other safeguards provide sufficient protection to the patients. The findings stated above are disclosable whether or not a plan of correction is provided. The findings are disclosable within 14 days after such information is made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

This form is a printed electronic version of the CMS 2567L. It contains all the information found on the standard document in much the same form. This electronic form once printed and signed by the facility administrator and appropriately posted will satisfy the CMS requirement to post survey information found on the CMS 2567L.

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F 0620 SS=D	Continued from page 1 483.15(a)(1)-(7) Admissions Policy §483.15(a) Admissions policy. §483.15(a)(1) The facility must establish and implement an admissions policy. §483.15(a)(2) The facility must- (i) Not request or require residents or potential residents to waive their rights as set forth in this subpart and in applicable state, federal or local licensing or certification laws, including but not limited to their rights to Medicare or Medicaid; and (ii) Not request or require oral or written assurance that residents or potential residents are not eligible for, or will not apply for, Medicare or Medicaid benefits. (iii) Not request or require residents or potential residents to waive potential facility liability for losses of personal property. §483.15(a)(3) The facility must not request or require a third party guarantee of payment to the facility as a condition of admission or expedited admission, or continued stay in the facility. However, the facility may request and require a resident representative who has legal access to a resident's income or resources available to pay for facility care to sign a contract, without incurring personal financial liability, to provide facility payment from the resident's income or resources. §483.15(a)(4) In the case of a person eligible for Medicaid, a	F 0620	Residents R1, R2, R3 admission paperwork has been corrected. Whole house audit of correct admission paperwork will be completed for all residents to ensure that patient with a BIMS of 13 or higher or family has reviewed and signed all proper paperwork. Education with Admission Director and Concierge on facility and state regulation of admission paperwork will be performed to ensure all paperwork is done upon admission. BIMS will be checked prior to patient signing. Admissions paperwork will be signed by resident with a BIMS of 13-15 which indicates patient is cognitively intact. Audits to be completed by Admissions or designee 3 times a week x2 weeks, 2 times a week x2 weeks, 1x a week x2 weeks. This plan of correction will be monitored at the monthly Quality Assurance meeting until substantial compliance has been met.	Completion Date: **01/14/2025** Status: **APPROVED** Date: **01/02/2025**

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F 0620 SS=D	Continued from page 2 nursing facility must not charge, solicit, accept, or receive, in addition to any amount otherwise required to be paid under the State plan, any gift, money, donation, or other consideration as a precondition of admission, expedited admission or continued stay in the facility. However,- (i) A nursing facility may charge a resident who is eligible for Medicaid for items and services the resident has requested and received, and that are not specified in the State plan as included in the term "nursing facility services" so long as the facility gives proper notice of the availability and cost of these services to residents and does not condition the resident's admission or continued stay on the request for and receipt of such additional services; and (ii) A nursing facility may solicit, accept, or receive a charitable, religious, or philanthropic contribution from an organization or from a person unrelated to a Medicaid eligible resident or potential resident, but only to the extent that the contribution is not a condition of admission, expedited admission, or continued stay in the facility for a Medicaid eligible resident. §483.15(a)(5) States or political subdivisions may apply stricter admissions standards under State or local laws than are specified in this section, to prohibit discrimination against individuals entitled to Medicaid. §483.15(a)(6) A nursing facility must disclose and provide to a resident or potential resident prior to time of admission, notice of special characteristics or service limitations of the facility.	F 0620		

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F 0620 SS=D	Continued from page 3 §483.15(a)(7) A nursing facility that is a composite distinct part as defined in §483.5 must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under paragraph (c)(9) of this section. This REQUIREMENT is not met as evidenced by:	F 0620		

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F 0620 SS=D	Continued from page 4 Based on review of resident records, admission documentation and staff interview, it was determined that the facility failed to maintain admission documentation three two of seven residents (Resident R1, R2, R3). Findings include: Review of Resident R96 was admitted 11/27/24 with diagnoses that include cytomegaloviral disease (common virus that infects people of all ages and can cause a range of symptoms), diabetes mellitus and protein calorie malnutrition. Review of the Resident Assessment Instrument 3.0 User's Manual effective October 2019, 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: 13-15: cognitively intact 8-12: moderately impaired	F 0620		

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STATE LICENSE NUMBER: **070302**	

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F 0620 SS=D	Continued from page 5 0-7: severe impairment Review of Resident R1 Admission MDS assessment (Minimum Data Set assessment MDS- a periodic assessment of resident care needs) dated 12/3/24 indicated the resident was assessed as having a BIMS score of 11, which indicates moderately impaired. Review of Resident R1's admission packet indicated a signature by the resident. Review of Resident R2 was admitted 11/21/24 with diagnoses that include encephalopathy (brain disorder that affects the brain's structure or function), chronic kidney disease and anemia. Review of Resident R2's medical record revealed no signed admission packet. Review of Resident R3 was admitted 11/26/24 with diagnoses that include multiple fracture of the ribs, urinary tract infection and lack of coordination.	F 0620		

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F 0620 SS=D	Continued from page 6 Review of Resident R3's medical record revealed no signed admission packet. During an interview with Nursing Home Administrator on 12/19/24 at 2:00 p.m. confirmed Resident R1 was cognitively impaired and should not have signed facility paperwork and R2 and R3 never had admission paper work completed as required. 28 Pa Code: 201.18(b)(2) Management. 28 Pa Code: 201.24(a) Admission policy. 28 Pa Code: 201.19(i) Residents rights.	F 0620		
F 0812 SS=D		F 0812		

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F 0812 SS=D	Continued from page 7 483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by:	F 0812	1st , 2nd, and 3rd floor nursing kitchen pantries were cleaned and all food items without dates have been removed. All new food items and resident snacks will have proper date and will be discarded after 3 days per protocol. Education to Dietary Director and dietary employees on labeling and dating all food/drink items that are distributed from kitchen. Education also provided to nursing staff that all non-patient related items are not permitted in patient pantries. Audits to be performed by Director of Nursing or Designee 3 times a week x2 weeks, 2 times a week x2 weeks, 1 time a week x2 weeks to ensure all pantries are clean, organized, and proper dates are used. This plan of correction will be monitored at the monthly Quality Assurance meeting until substantial compliance has been met.	Completion Date: **01/14/2025** Status: **APPROVED** Date: **01/02/2025**

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F 0812 SS=D	Continued from page 8 Based on observations and staff interview, it was determined that the facility failed to properly label and date food products on the nursing unit pantries which created the potential for cross contamination in the designated kitchen pantries. Findings include: During an observation of 3rd floor nursing pantry refrigerator, the following was observed: - 1 McDonald milkshake no label or date - 1 cottage cheese/fruit no label or date - 1 Celsius no label or date - 1 acai bowl in freezer no label or date - 1 frozen sandwich no label or date - 1 pumpkin cheesecake ice cream no label or date 3rd floor nursing pantry storage - 2 bowls of raisin bran no label or date - 1 box of donuts no label or date 2nd floor nursing pantry storage - 1 container of ramen, cup, no label or date - 1 square package of ramen, no label or date	F 0812		

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F 0812 SS=D	Continued from page 9 During an interview on 12/19/24 at 10:35 a.m., Licensed Practical Nurse (LPN) Employee E1 confirmed that the facility failed to properly label and date food products 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 license.	F 0812		

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P 5520		P 5520		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: | (X6) DATE:

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P 5520	Continued from page 1 Nursing services. (3) Effective July 1, 2024, a minimum of 1 nurse aide per 10 residents during the day, 1 nurse aide per 11 residents during the evening, and 1 nurse aide per 15 residents overnight. This REGULATION is not met as evidenced by:	P 5520	There were no adverse effects to the residents of our facility as a result of the decreased nurse aide to resident ratios on 12/1/24 through 12/18/24. The Director of Nursing, Human Resources, and the Scheduler will be re-educated on new July 1 nurse aide to resident ratios by the Nursing Home Administrator or Desginee. To ensure sufficient nursing aide staffing ratios to comply with state laws, staffing meetings will be held 3 days a week to review staffing and the projected nursing assistant staff ratios for the current day, as well as the upcoming week. If projected staffing levels are below the required minimum staffing ratios, then the facility will reach out to current staff and to the staffing agencies to enlist staff to meet the minimum staffing and ratio requirement. Facility will continue to recruit CNAs through all platforms and utilize bonuses and outside staffing agencies. Audits of nurse aide ratios will be completed weekly x4 by the	Completion Date: **01/14/2025** Status: **APPROVED** Date: **01/02/2025**

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P 5520	Continued from page 2	P 5520	NHA/designee to ensure nurse aide ratios are met. Results of the audits will be reported to our QAPI committee monthly for review and recommendations.	

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P 5520	Continued from page 3 Based on review of nursing time schedules and staff interviews, it was determined that the facility administrative staff failed to provide a minimum of one nurse aide (NA) per 10 residents during the day shift for eleven of 18 days (12/5/24, 12/6/24, 12/8/24, 12/9/24, 12/10/24, 12/12/24, 12/13/24, 12/14/24, 12/15/24, 12/16/24 and 12/18/24), one nurse aide per 11 residents on evening shift for eleven of 18 days (12/2/24, 12/5/24, 12/6/24, 12/7/24, 12/10/24, 12/12/24, 12/13/24, 12/15/24, 12/16/24, 12/17/24 and 12/18/24), and one nurse aide per 15 residents on night shift for three of 18 days (12/6/24, 12/12/24 and 12/17/24). Findings include: Nursing time schedules for the time frame of 12/1/24 through 12/18/24, revealed the following NA staffing shortages. Day shift: 12/5/24 census 85 8.46 present	P 5520		

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P 5520	Continued from page 4 8.50 required 12/6/24 census 85 8.17 present 8.50 required 12/8/24 census 87 8.44 present 8.70 required 12/9/24 census 85 7.38 present 8.50 required 12/10/24 census 85 8.02 present 8.50 required 12/12/24 census 87 8.22 present 8.70 required 12/13/24 census 87 8.43 present 8.70 required 12/14/24 census 86 4.30 present 8.60 required 12/15/24 census 85 5.26 present 8.50 required 12/16/24 census 87 6.62 present 8.70 required 12/18/24 census 87 8.60 present 8.70 required Evening shift:	P 5520		

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P 5520	Continued from page 5	P 5520		

12/2/24 census 87 7.59 present
7.91 required
12/5/24 census 85 6.39 present
7.73 required
12/6/24 census 85 5.08 present
7.73 required
12/7/24 census 84 6.39 present
7.64 required
12/10/24 census 85 6.78 present
7.73 required
12/12/24 census 87 6.61 present
7.91 required
12/13/24 census 87 5.39 present
7.91 required
12/15/24 census 85 6.38 present
7.73 required
12/16/24 census 87 5.72 present
7.91 required
12/17/24 census 86 6.73 present
7.82 required
12/18/24 census 87 7.14 present
7.91 required

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
P 5520	Continued from page 6 Night shift: 12/6/24 census 85 5.42 present 5.67 required 12/12/24 census 87 5.41 present 5.80 required 12/17/24 census 86 5.34 present 5.73 required During an interview on 12/19/24, at 2:00 p.m. the Nursing Home Administrator confirmed that the facility failed to provide a minimum of one nurse aide (NA) per 10 residents during the day shift for eleven of 18 days (12/5/24, 12/6/24, 12/8/24, 12/9/24, 12/10/24, 12/12/24, 12/13/24, 12/14/24, 12/15/24, 12/16/24 and 12/18/24), one nurse aide per 11 residents on evening shift for eleven of 18 days (12/2/24, 12/5/24, 12/6/24, 12/7/24, 12/10/24, 12/12/24, 12/13/24, 12/15/24, 12/16/24, 12/17/24 and 12/18/24), and one nurse	P 5520		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395011	A. BLDG: __00_____ B. WING: _____	12/19/2024

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P 5520	Continued from page 7 aide per 15 residents on night shift for three of 18 days (12/6/24, 12/12/24 and 12/17/24), with no additional excess higher-level staff to compensate this deficiency.	P 5520		
P 5530		P 5530		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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P 5530	Continued from page 8 Nursing services. (4) Effective July 1, 2023, a minimum of 1 LPN per 25 residents during the day, 1 LPN per 30 residents during the evening, and 1 LPN per 40 residents overnight. This REGULATION is not met as evidenced by:	P 5530	There were no adverse effects to the residents of our facility as a result of decreased licensed nurse staffing ratios on 12/14/24. The Director of Nursing, Human Resources, and the Scheduler will be re-educated on new July 1 licensed nurse to resident ratios by the Nursing Home Administrator or Designee. Staffing meetings will be held 3 days a week to review the licensed nursing staff ratios for the previous and current day, as well as the upcoming week to ensure appropriate staffing levels. If projected staffing levels are below the state mandated ratios, then the facility will reach out to current staff and to the staffing agencies to enlist staff to meet the minimum requirement. Facility will continue to recruit nursing staff through all platforms as well as utilize bonus structures and outside agencies. Audits of licensed nursing staff ratios will be completed weekly x4 by the NHA/designee to ensure	Completion Date: **01/14/2025** Status: **APPROVED** Date: **01/02/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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P 5530	Continued from page 9	P 5530	licensed staff ratios meet the state minimums. Results of the audits will be reported to our QAPI committee monthly for review and recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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P 5530	Continued from page 10 Based on review of nursing time schedules and staff interviews it was determined that the facility administrative staff failed to provide a minimum of one Licensed Practical Nurse (LPN) per 40 residents on night shift for one of 18 days (12/14/24). Findings include: Nursing time schedules for the time frame of 12/1/24 through 12/18/24, revealed the following LPN staffing shortage. Night shift: 12/14/24 census 86 3.04 present 3.44 required. During an interview on 12/19/24, at 2:00 p.m. the Nursing Home Administrator confirmed that the facility failed to provide a minimum of one Licensed Practical Nurse (LPN) per 25 residents on day shift for one of 18 days (12/14/24), with no additional	P 5530		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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P 5530	Continued from page 11 excess higher-level staff to compensate this deficiency.	P 5530		
P 5640		P 5640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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P 5640	Continued from page 12 Nursing services. (2) Effective July 1, 2024, the total number of hours of general nursing care provided in each 24-hour period shall, when totaled for the entire facility, be a minimum of 3.2 hours of direct resident care for each resident. This REGULATION is not met as evidenced by:	P 5640	There were no adverse effects to the residents of our facility as a result of decreased HPPD on 12/1/24 through 12/17/24. The Director of Nursing, HR and Scheduler will be re-educated on the state requirement for HPPD by the Nursing Home Administrator or Designee. Staffing meetings will be held 3 days a week to review HPPD from the previous day and the projected HPPD, as well as the upcoming week to ensure appropriate staffing levels. If projected staffing levels are below the minimum of 3.2 HPPD, then the facility will reach out to current staff and staffing agencies to enlist staff to meet the minimum requirement. Facility will continue to recruit staff through all platforms. Audits of HPPD will be completed 5 days a week x4 by the NHA/designee to ensure HPPD meets the state minimums. Results of the audits will be submitted to the QAPI committee monthly for review	Completion Date: **01/14/2025** Status: **APPROVED** Date: **01/02/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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P 5640	Continued from page 13	P 5640	and recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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P 5640	Continued from page 14 Based on review of nursing time schedules and staff interviews it was determined that the facility administrative staff failed to provide the minimum number of general nursing hours to each resident in a 24-hour period on ten of 18 days (12/1/24, 12/5/24, 12/6/24, 12/9/24, 12/12/24, 12/13/24, 12/14/24, 12/15/24, 12/16/24 and 12/17/24). Findings include: Review of the nursing schedules and census information for 12/1/24 through 12/18/24, revealed that the facility failed to maintain 3.20 hours of general nursing care (PPD) to each resident in a 24-hour period on the following dates: 12/1/24 census 90 PPD 3.19 12/5/24 census 85 PPD 3.13 12/6/24 census 85 PPD 2.94 12/9/24 census 85 PPD 3.12 12/12/24 census 87 PPD 2.95 12/13/24 census 87 PPD 2.97 12/14/24 census 86 PPD 2.91	P 5640		

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P 5640	Continued from page 15 12/15/24 census 85 PPD 2.97 12/16/24 census 87 PPD 3.14 12/17/24 census 86 PPD 3.10 During an interview on 12/19/24, at 2:00 p.m. the Nursing Home Administrator confirmed that the failed to provide the minimum number of general nursing hours to each resident in a 24-hour period on ten of 18 days (12/1/24, 12/5/24, 12/6/24, 12/9/24, 12/12/24, 12/13/24, 12/14/24, 12/15/24, 12/16/24 and 12/17/24).	P 5640		

Certified End Page

PLATINUM RIDGE CENTER FOR REHABILITATION AND HEALING

STATE LICENSE NUMBER: 070302

SURVEY EXIT DATE: 12/19/2024

I Certify This Document to be a True and Correct Statement of Deficiencies and Approved Facility Plan of Correction for the Above-Identified Facility Survey

Jeanne Parisi
Deputy Secretary for Quality Assurance

Debra L. Bogen MD
Debra L. Bogen, MD, FAAP
Secretary of Health

Pennsylvania
Department of Health

THIS IS A CERTIFICATION PAGE

PLEASE DO NOT DETACH

THIS PAGE IS NOW PART OF THIS SURVEY