STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395015	A. BLDG: 00 B. WING:	02/14/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
BRIGHTON REHABILITATION AND WELLNESS CENTER STATE LICENSE NUMBER: **020802**	**246 FRIENDSHIP CIRCLE** **BEAVER, PA 15009**

(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 a Medicare/Medicaid Recertification survey, State Licensure survey, Civil Rights Compliance, and an Abbreviated survey in response to 13 complaints completed on February 14, 2025, it was determined that Brighton Rehabilitation and Wellness Center was not in compliance with the following requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care and the 28 Pa. Code, Commonwealth of Pennsylvania Long Term Care Licensure Regulations	F 0000		
F 0550 SS=D		F 0550		

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 0550 SS=D	Continued from page 1 483.10(a)(1)(2)(b)(1)(2) Resident Rights/Exercise of Rights §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.	F 0550	1. R149 was offered a blanket to cover his lap. Employee E3 was educated on maintaining dignity by dating dressings for residents prior to placing on the body. Residents whom received plastic cutlery on 2/10/25 through 2/12/2025 suffered no ill effects. 2. Walking rounds were done on 2/13/2025 by assistant director of nursing to ensure that residents who were out of bed were covered appropriately. No issues identified. 3. Director of nursing or designee will in service licensed nursing staff on dating wound dressings prior to placing on a resident. Director of nursing or designee will educate nursing staff on maintaining dignity by ensuring residents are covered appropriately. Administrator or designee will in-service dietary staff on providing metal cutlery unless otherwise ordered. 4. Director of nursing or designee will observe 5 dressing changes weekly for 2 weeks, then 3 dressing changes weekly for 2 weeks, then 3 dressing changes monthly for 2	Completion Date: **03/10/2025** Status: **APPROVED** Date: **02/28/2025**

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F 0550 SS=D	Continued from page 2 §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by:	F 0550	months to ensure dressings are dated prior to being placed on resident. Director of nursing/designee will audit 6 units weekly for 2 weeks, then 3 units weekly for 2 weeks, then 3 units monthly for 2 months to ensure residents are covered appropriately. Audit findings will be shared with QAPI committee. Administrator or designee will audit meal trays weekly for 4 weeks to ensure metal cutlery is being provided.	

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F 0550 SS=D	Continued from page 3 Based on review of facility policy, observations, and staff interviews, it was determined that the facility failed to ensure that care was provided in a manner which maintained resident dignity for two of six residents (Residents R149 and R169) and the facility failed to provide the right to a dignified dining experience for two of two lunches observed. Findings include: Review of facility policy "Resident Rights" dated 10/1/24, indicated the resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility. Review of the clinical record indicated Resident R149 was admitted to the facility on 9/22/15. Review of Resident R149's Minimum Data Set (MDS - a periodic assessment of care needs) dated 1/2/25, indicated diagnoses of high blood pressure, heart failure (a progressive heart disease that affects	F 0550		

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F 0550 SS=D	Continued from page 4 pumping action of the heart muscles), and dementia (a group of symptoms that affects memory, thinking and interferes with daily life). During an observation on 2/11/25, at 10:45 a.m. Resident R149 was sitting in his wheelchair, self-propelling in the hallway with other residents wearing a sweatshirt, socks, and a brief (adult protective underwear). Resident R149 failed to have clothing on to cover up his lower body. During an interview on 2/11/25, at 10:49 a.m. Licensed Practical Nurse (LPN) Employee E18 stated, "He does this all the time, I'll try to cover him up". During an interview on 2/11/25, at 10:51 a.m. LPN Employee E18 confirmed that Resident R149 should have been dressed appropriately and failed to maintain Resident R149's dignity by allowing him to self- propel around nursing unit in his brief. Review of the clinical record indicated Resident	F 0550		

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F 0550 SS=D	Continued from page 5 R169 was admitted to the facility on 4/10/24. Review of Resident R169's MDS dated 12/23/24, indicated diagnoses of high blood pressure, anemia (too little iron in the blood), and hip fracture. Review of the facility provided pressure ulcer list indicated Resident R169 developed a pressure ulcer (injury to skin and underlying tissue resulting from prolonged pressure on the skin) to her right buttock on 1/9/25. During an observation of wound care on 2/13/25, from 11:04 a.m. through 11:42 a.m. Wound Care Registered Nurse Employee E3 wrote on the dressing after it was placed on Resident R169's right buttock. During an interview on 2/13/25, at 11:44 a.m. Wound Care Registered Nurse Employee E3 confirmed the facility failed to maintain Resident R169's dignity when writing on the dressings after placement on the resident.	F 0550		

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F 0550 SS=D	Continued from page 6 During a lunch time observation on 2 Main Dining Room on 2/10/25 all residents were observed with plastic utensils. 3 Main Dining Room on 2/10/25 all residents were observed to have plastic utensils. During a lunch time observation on 2 Main Dining Room on 2/11/25 all residents were observed with plastic utensils. 3 Main Dining Room on 2/11/25 all residents were observed to have plastic utensils. During the tray line observation on 2/12/25 at 11:30 a.m. all resident trays were observed with plastic utensils. During an interview on 2/12/25, at 11:45 a.m. Dietary Manager Employee E23 confirmed the facility failed to provide metal silverware to residents, therefore failing to provide a dignified dining experience. 28 Pa. Code: 201.29(j) Resident rights.	F 0550		

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F 0554 SS=D	483.10(c)(7) Resident Self-Admin Meds-Clinically Approp §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by:	F 0554	1. R811 was assessed for ability to self-administer medications. Physician order was obtained and care plan was revised. Treatment creams and supplies were removed from bedside for R812. R812 is unable to self-administer treatments. 2. A house audit was done to ensure residents who have medications at bedside have proper assessments, orders and care plans. No issues identified. 3. Director of nursing or designee will in service licensed nurses on not leaving medications or treatments at bedside unless the resident has been assessed to safely self-administer and has physician order to do so. 4. Director of nursing or designee will audit 10 residents weekly for 2 weeks, then 5 residents weekly for 2 weeks, then 5 residents monthly for 2 months to ensure residents do not have medications or treatments left at bedside unless they have proper assessment and physician order to do so. Audit findings will be shared with QAPI committee.	Completion Date: **03/10/2025** Status: **APPROVED** Date: **02/28/2025**

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F 0554 SS=D	Continued from page 8 Based on review of facility policy, observations and staff interview, it was determined that that the facility failed to determine it was safe to self-administer medications for two of six residents (Resident R811 and R812). Findings include: Review of the facility policy "Self-Administration of Medications" dated 10/1/24, indicated residents have the right to self-administer medications if ordered by the physician, and the resident is competent to safely self-administer the medications as determined by the interdisciplinary team. Review of the clinical record revealed that Resident R811 was admitted to the facility on 1/29/25. Review of Resident 811's MDS (Minimum Data Set, periodic assessment of resident care needs) dated 2/5/25, indicated diagnoses of alcoholic cardiomyopathy (the heart is unable to pump blood efficiently, leading to heart failure from prolonged	F 0554		

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F 0554 SS=D	Continued from page 9 alcohol consumption), sarcoidosis of lung (autoimmune disease where the immune system starts attacking the body, forming small inflammatory lumps called granulomas), and depression. Review of Resident R811's physician orders dated 1/29/25, indicated to administer Breo Ellipta (medication used to long term to prevent and control wheezing) one puff inhaled daily for chronic obstructive pulmonary disease (COPD- a group of diseases that block airflow and make it hard to breathe). Observation on 2/10/25, at 9:24 a.m. a Breo Ellipta inhaler was noted to be on the overbed table of Resident R811. Review of Resident R811's clinical record on 2/10/25, at 9:30 a.m., failed to include a care plan, order for self-administration of medications, or an interdisciplinary assessment. During an interview on 2/10/25, at 9:45 a.m. Unit	F 0554		

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F 0554 SS=D	Continued from page 10 Director Registered Nurse (RN) Employee E6 confirmed Resident R811 did not have a current order, care plan to self-administer medications, or an interdisciplinary assessment. Review of the admission record indicated Resident R812 was re-admitted to the facility on 2/7/25, with diagnosis that included angina pectoris (chests pain caused by reduced blood flow to the heart), cardiomyopathy (disease of the heart that makes it hard for the heart to deliver blood to the body), intracardiac thrombosis (blood clot in the heart's chambers). Observation on 2/10/25, at 9:30 a.m. Resident R812 was sitting on bed, Desenex powder (treats fungal infections), and triamcinolone cream (a steroid cream to treat inflammatory conditions) were on the bedside table, along with two bottles of betadine on the windowsill. Review of Resident R812's clinical record on 2/10/25, at 9:35 a.m., failed to include a care plan,	F 0554		

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F 0554 SS=D	Continued from page 11 order for self-administration of medications, or an interdisciplinary assessment. During an interview on 2/10/25, at 9:45 a.m. Unit Director RN Employee E6 confirmed Resident R812 did not have a current order, care plan to self-administer medications, or an interdisciplinary assessment. During an interview on 2/14/25, at 12:30 p.m. the Director of Nursing confirmed the facility failed to determine it was safe to self-administer medications for two of six residents (Resident R811 and R812). 28 Pa. Code 201. 18(b)(1) Management 28 Pa Code:201.29(a)(d) Resident rights 28 Pa code:211.10(c)(d) Resident care policies 28 Pa Code:211.12(a)(c)(d)(1)(2)(5) Nursing services	F 0554		
F 0583 SS=D		F 0583		

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F 0583 SS=D	Continued from page 12 483.10(h)(1)-(3)(i)(ii) Personal Privacy/Confidentiality of Records §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(h)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in	F 0583	1. Laptop on Grove 1 back hall medication cart was closed to conceal protected health information. 2. Walking rounds were done by assistant director of nursing to ensure no medication cart laptops were found open and unattended on other units. No further issues identified. 3. Director of nursing or designee will in service nursing staff on protecting personal privacy and confidentiality by ensuring medication laptops are closed when unattended. 4. Director of nursing or designee will audit 5 units (10 medication carts) weekly for 2 weeks, then 3 units (6 medication carts) weekly for 2 weeks, then 3 units (6 medications carts) monthly for 2 months to ensure no confidential information is openly visible to others. Audit findings will be shared with QAPI committee.	Completion Date: **03/10/2025** Status: **APPROVED** Date: **02/28/2025**

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F 0583 SS=D	Continued from page 13 accordance with State law. This REQUIREMENT is not met as evidenced by:	F 0583		

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F 0583 SS=D	Continued from page 14 Based on review of facility policy, observation, and staff interview it was determined that the facility failed to maintain the confidentiality of residents' medical information on one of 12 medication carts (Grove One- Back Medication Cart). Findings include: Review of facility policy "Health Insurance Portability and Accounting Act (HIPAA) of 1996" dated 10/1/24, indicated the facility will keep information regarding a resident's health private and confidential. Do not allow any papers, documents, or any other format with resident information unattended. During an observation on 2/12/25, at 9:17 a.m. the Grove One Back Medication Cart at the nurses station was left unattended with the computer screen open with identifiable information any passerby could see resident personal and confidential information.	F 0583		

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F 0583 SS=D	Continued from page 15 During an interview on 2/12/25, at 9:20 a.m. Registered Nurse Employee E10 confirmed the above observation. During an interview on 2/12/25, at 11:56 a.m. the Director of Nursing confirmed that the facility failed to maintain the confidentiality of residents' medical information as required. 28 Pa. code: 211.5(b) Clinical records. 28 Pa. Code: 201.29(i) Resident Rights. 28 Pa. Code: 211.12(d)(3) Nursing Services.	F 0583		
F 0584 SS=D		F 0584		

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NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
BRIGHTON REHABILITATION AND WELLNESS CENTER STATE LICENSE NUMBER: **020802**	**246 FRIENDSHIP CIRCLE BEAVER, PA 15009**

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F 0584 SS=D	Continued from page 16 483.10(i)(1)-(7) Safe/Clean/Comfortable/Homelike Environment §483.10(i) Safe Environment. 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. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all	F 0584	1. Room 430 was cleaned; trash was removed from room, floor was mopped, bedside commode was emptied and sanitized, and overbed table was cleaned. The ceiling in room 409 was cleaned. Missing metal from vent in 4 main common bathroom was fixed. Stained ceiling tiles on units 4 main and 5 Main were replaced. Ceiling vents and common room ceiling fan on 5 main. Privacy curtains were changed in rooms 406, 416, 512, 513, 518 and common bathroom on 5 main. Wall patches on 5 main will be painted. 2. Maintenance director and Environmental Services director will round units to check for items in need of cleaning or repair, items will be addressed by respective departments. 3. Administrator or designee will in-service maintenance and environmental services departments on maintaining a safe, comfortable, clean home like environment. 4. Administrator or designee will round 5 units weekly for 2 weeks, then 3 units weekly for 2 weeks, then	Completion Date: **03/10/2025** Status: **APPROVED** Date: **02/28/2025**

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F 0584 SS=D	Continued from page 17 areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by:	F 0584	5 units monthly for 2 months to ensure maintenance and environmental service issues are being addressed in a timely manner. Audit findings will be shared with QAPI committee.	

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F 0584 SS=D	Continued from page 18 Based on review of facility policy, resident council group interview, observations and staff interviews it was determined that the facility failed to provide a clean, safe, comfortable, and homelike environment for two of 12 nursing units (Four and Five Main Nursing Units.) Findings include: Review of the facility policy "Resident Environment" dated 10/1/24, indicated the facility will provide an environment that is safe, clean, comfortable, and homelike, allowing the resident to use his or her personal belongings to the extent possible. Review of Title 42 Code of Federal Regulations §483.10(i) Safe Environment. 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. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.	F 0584		

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F 0584 SS=D	Continued from page 19 During a resident council group interview on 2/12/25, at 11:01 a.m. two out of 11 residents voiced concerns with facility cleanliness. On 2/12/25, at 1:00 p.m. observation of four main nursing unit included: - Room 430 floor was dirty with garbage laying all over the floor. - Room 430 floor was brown, sticky and black marks noted. - Room 430 bedside commode was used and not clean. - Room 430 overbed table observed with dirt and stains on the frame During an interview on 2/12/15, at 1:05 Licensed Practical Nurse (LPN) Employee E14 confirmed the above findings. On 2/13/25, at 1:15 p.m. observation of five main nursing unit included:	F 0584		

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F 0584 SS=D	Continued from page 20 - Multiple brown stained ceiling tile throughout the five main nursing unit - Dust noted around ceiling vents - Residents' common bathroom privacy curtains were dirty and stained - Room 512-2 window curtain stained - Room 513-3 window curtain stained - Common room ceiling fan dusty and dust on ceiling tiles - Room 518-2 privacy curtain stained - Patches on the walls in the hallway throughout the unit not painted. During an interview on 2/13/25, at 1:45 LPN Employee E13 confirmed the above findings. On 2/13/25, at 2:00 p.m. observation of four main nursing unit included: - Multiple brown stained ceiling tile throughout the four main nursing unit - Resident common bathroom was missing a piece	F 0584		

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F 0584 SS=D	Continued from page 21 of metal from a vent - Room 406-1 privacy curtain was marked with a brown stain - Room 409 ceiling in multiple areas had visible splatter marks - Room 416-2 privacy curtain was marked with brown stains On 2/13/25, at 2:05 p.m. LPN Employee E14 confirmed the above findings. During an interview on 2/13/25, at 3:00 p.m. Director of Nursing confirmed that the facility failed to provide a clean, safe, comfortable, and homelike environment for two of 12 nursing units (Four and Five Main Nursing Units). 28 Pa. Code 201.18(b)(3)(e)(2) Management. 28 Pa code 211.12(d)(1) Nursing services.	F 0584		

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F 0584 SS=D	Continued from page 22	F 0584		
F 0585 SS=D		F 0585		

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F 0585 SS=D	Continued from page 23 483.10(j)(1)-(4) Grievances §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance	F 0585	1. Grievance forms and policy were placed in resident common areas on 2 east and 3 east. 2. A house audit was completed of all other resident units to ensure grievances and grievance policy were present and easily accessible to residents. No further issues identified. 3. Director of nursing will in-service social workers on ensuring grievance policy and grievance forms are readily accessible to residents on all units. 4. Director of social services or designee will audit 3 units weekly for 2 weeks, then 2 units weekly for 2 weeks, then 3 units monthly for 2 months to ensure grievance forms and policy are accessible to residents. Audit findings will be shared with QAPI committee.	Completion Date: **03/10/2025** Status: **APPROVED** Date: **02/28/2025**

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F 0585 SS=D	Continued from page 24 can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the	F 0585		

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F 0585 SS=D	Continued from page 25 date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by:	F 0585		

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F 0585 SS=D	Continued from page 26 Based on review of facility policy, resident interview, observations of resident areas and nursing units, and staff interviews it was determined that the facility failed to make certain anonymous grievance forms are readily accessible for resident use and the facility failed to post the grievance procedure in prominent areas for two of 12 nursing units (Two East nursing unit and Three East nursing unit). Findings include: The facility "Grievances/Concerns" policy dated 10/1/24, indicated that the grievance/Complaint form will be submitted to the Grievance Official, who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusion, leading any necessary investigations by the facility, maintaining confidentiality of all information associated with the grievance, issuing written grievance decisions to the resident, and coordinating with state and federal agencies as necessary. A copy of the grievance/complaint procedure is posted in	F 0585		

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F 0585 SS=D	Continued from page 27 prominent locations throughout the facility. During an interview on 2/11/25, at 9:46 a.m. Resident R7 stated the following: "I've been here two and a half years. There are no grievance forms. The employees that do dirt and know we cannot complaint, they know they will not get reported." During a tour on 2/11/25, at 12:02 p.m. the Two East nursing unit and resident solarium/common area was observed without grievance forms for resident use and without a grievance policy posted. During a tour on 2/12/25, at 9:34 a.m. the Two East nursing unit and resident solarium/common area was observed without grievance forms for resident use and without a grievance policy posted. During an interview on 2/12/25, at 9:37 a.m. interview with Licensed Practical Nurse (LPN) Supervisor Employee E7 confirmed that the facility failed to make certain anonymous grievance forms are readily accessible for resident use as required.	F 0585		

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F 0585 SS=D	Continued from page 28 During a tour on 2/12/25, 12:26 p.m. Three East nursing unit and resident solarium/common area was observed Three East found the grievance procedure posted in the hallway without a name of compliance officer and without a mailing address. During an interview on 2/12/25, at 12:28 p.m. Registered Nurse (RN) Supervisor Employee E8 confirmed that the facility failed to make certain anonymous grievance forms are readily accessible for resident use and the facility failed to post the grievance procedure in prominent areas as required. 28 Pa Code: 201.29(l) Resident rights 28 Pa Code: 201.18 (e)(4) Management	F 0585		
F 0610 SS=D		F 0610		

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F 0610 SS=D	Continued from page 29 483.12(c)(2)-(4) Investigate/Prevent/Correct Alleged Violation §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by:	F 0610	1. The facility is unable to retroactively correct the deficiency as it relates to R456, who is no longer a resident in the facility. 2. An audit will be done by director of nursing of all investigations conducted in the last 30 days to ensure witness statements were collected. 3. Director of nursing or designee will in-service nursing leadership team on collecting witness statements for unusual occurrences concerning residents to rule out neglect. 4. Director of nursing or designee will audit all investigation files for 4 weeks to ensure witness statements have been obtained as appropriate. Audit findings will be shared with QAPI committee.	Completion Date: **03/10/2025** Status: **APPROVED** Date: **02/28/2025**

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F 0610 SS=D	Continued from page 30 Based on review of facility policy, clinical record review and staff interview, it was determined that the facility failed to fully investigate an incident to eliminate possible abuse or neglect for one of three residents (Resident R456). Findings include: Review of the facility policy "Incident and Accident Reports" reviewed 10/1/24, indicated the facility will document all unusual occurrences and events. It was indicated an elopement requires an incident report to be completed. Review of the facility "Abuse: Protection From Abuse" reviewed 10/1/24, indicated an Accident or Incident Report Form must be completed for all reported accidents or incidents. An employee witnessing an accident or incident involving a resident, employee must report such occurrence to his or her immediate supervisor, as soon as practical. An investigation is implemented and witness statements are obtained.	F 0610		

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F 0610 SS=D	Continued from page 31 Review of Resident R456's admission record indicated he was admitted on 1/25/25. It was indicated the resident was admitted to the locked unit. Review of Resident R456's Minimum Data Set assessment (MDS -a periodic assessment of resident care needs) dated 2/1/25, included diagnoses of malignant neoplasm of brain (growth of cancerous cells in the brain), metabolic encephalopathy (change in how your brain works due to an underlying condition), and mood disorder due to physiological condition. Review of Section C0500-BIMS screening indicated a score of "10," which indicated Resident R456 was moderately impaired. Review of a progress note dated 2/3/25, at 8:35 p.m. entered by the Director of Nursing (DON) indicated the police were on site, a preliminary search of immediate area was done, and the resident was not located.	F 0610		

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	395015	A. BLDG: __00_____ B. WING: _____	02/14/2025

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F 0610 SS=D	Continued from page 32 Review of the facility's investigation for Resident R456's elopement on 2/10/25, at 12:30 p.m., failed to include any witness statements. During an interview on 2/10/25, at 12:54 p.m., the DON confirmed the facility failed fully investigate Resident R456's elopement to rule out neglect. The DON confirmed the facility failed to obtain witness statements. 28 Pa. Code: 201.149(a) Responsibility of licensee. 28 Pa. Code: 201.18(e)(1) Management.	F 0610		
F 0620 SS=D		F 0620		

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F 0620 SS=D	Continued from page 33 483.15(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	1. The residents responsible party was made aware per dated documentation of the patient liability. The New Admissions Director sent the Resident R247's, who was admitted in October 2022, the admissions packet to the responsible party for resident R247. 2. The new admission Director reviewed the last 30 days worth of admissions to ensure they received a copy of and review of the admission packet with the ability to sign or refuse 3. The New Admissions Director was re in serviced on communicating and issuing the admission packet to residents and or responsible parties on admission. 4. The New Admission Director will audit daily for two weeks to ensure incoming residents receive a copy of and review of the admission packet with the ability to sign or refuse. Audit findings will be shared with QAPI committee.	Completion Date: **03/10/2025** Status: **APPROVED** Date: **02/28/2025**

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F 0620 SS=D	Continued from page 34 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 35 §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 36 Based on review of facility policy, resident records, admissions documentation and staff interview it was determined that the facility failed to provide a comprehensive review of resident admission rights and maintain admission documentation for one out of out three sampled records (Resident R247). Findings include: The facility "Resident rights" policy dated last reviewed 10/1/24, indicated the facility will protect and promote the rights of each resident, and informing the resident about what rights and responsibilities he or she has. Review of Resident R247's admission record indicated she was admitted on 10/4/22. Review of Resident R247's diagnoses that included dementia (a condition characterized by memory loss and progressive or persistent loss of intellectual functioning), anxiety disorder (a medical condition creating a sense of acute fear, restlessness, and	F 0620		

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F 0620 SS=D	Continued from page 37 worry), and hypertension (a condition impacting blood circulation through the heart related to poor pressure). Review of Resident R247's transfer and discharge notice dated 8/20/24, indicated that Resident R247 was being discharged due to non-payment. Review of Resident R247's clinical records, social service notes, and communications with family did not include an admissions packet or discussion upon admission that included patient portion liability, the daily rate cost structure, resident rights, representative/resident appeal rights, potential obligations to pay from resident resources, Medicare process, Medicaid process, and the consequences for failure to pay. During an interview on 2/11/25, at 11:40 a.m. Director of social services Employee E9 stated: "there is no official POA (Power of Attorney) documents for Resident R247."	F 0620		

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F 0620 SS=D	Continued from page 38 During an interview on 2/12/25, at 10:05 a.m. Business Office manager Employee E31 stated the following: "Resident R247 does not have an admission record." During an interview on 2/12/25, at 10:19 a.m. the Admission Director Employee E21 confirmed that the facility failed to provide a comprehensive review of resident admission rights and maintain admission documentation for Resident R247 as required. 28 Pa Code: 201.18 (b)(2) Management. 28 Pa Code: 201.24 (a) Admission policy. 28 Pa Code: 201.19 (i) Resident rights.	F 0620		
F 0622 SS=E		F 0622		

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F 0622 SS=E	Continued from page 39 483.15(c)(1)(i)(ii)(2)(i)-(iii) Transfer and Discharge Requirements §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D) The health of individuals in the facility would otherwise be endangered; (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or (F) The facility ceases to operate. (ii) The facility may not transfer or discharge the resident	F 0622	1. Facility is unable to retroactively correct the deficiency as it relates to R39, R49, R73, R169, R460 and CR611. 2. Director of nursing reviewed facility policy on hospital transfers. Policy was updated to reflect documentation of documents sent to receiving hospital. 3. Director of nursing or designee will in-service licensed staff on completing facility transfer form indicating documents sent to receiving hospital when transferring a resident to an outside hospital. 4. Director of nursing or designee will audit 5 hospital transfers weekly for 2 weeks, then 3 hospital transfers for 2 weeks, then 3 hospital transfers monthly for 2 months to ensure documentation of records sent with resident are present. Audit findings will be shared with QAPI committee.	Completion Date: **03/10/2025** Status: **APPROVED** Date: **02/28/2025**

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F 0622 SS=E	Continued from page 40 while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose. §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i) (A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (i) Documentation in the resident's medical record must include: (A) The basis for the transfer per paragraph (c)(1)(i) of this section. (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). (ii) The documentation required by paragraph (c)(2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and	F 0622		

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F 0622 SS=E	Continued from page 41 (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. This REQUIREMENT is not met as evidenced by:	F 0622		

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F 0622 SS=E	Continued from page 42 Based on review of 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 six of six residents sampled with facility-initiated transfers (Residents R39, R49, R73, R169, R460, and Closed Resident Record CR611). Findings include: Review of the clinical record indicated Resident R39 was admitted to the facility on 9/7/24. Review of Resident R39's Minimum Data Set (MDS - a periodic assessment of care needs) dated 1/30/25, indicated diagnoses of high blood pressure, diabetes (a metabolic disorder in which the body has high sugar levels for prolonged periods of time), and heart failure (a progressive heart disease that affects pumping action of the heart muscles). Review of Resident R39's clinical record revealed	F 0622		

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F 0622 SS=E	Continued from page 43 that the resident was transferred to the hospital on 11/24/24. Review of Resident R39'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 resident's specific needs at the receiving facility. Review of the clinical record indicated Resident R49 was admitted to the facility on 2/26/24. Review of Resident R49's MDS dated 11/22/24, indicated diagnoses of high blood pressure, heart failure, and acquired absence of left leg below knee. Review of Resident R49's clinical record revealed that the resident was transferred to the hospital on	F 0622		

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F 0622 SS=E	Continued from page 44 11/11/24. Review of Resident R49'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 resident's specific needs at the receiving facility. Review of the clinical record indicated Resident R73 was admitted to the facility on 6/20/24. Review of Resident R73's MDS dated 11/20/24, indicated diagnoses of high blood pressure, diabetes, and depression. Review of Resident R73's clinical record revealed that the resident was transferred to the hospital on 7/7/24.	F 0622		

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F 0622 SS=E	Continued from page 45 Review of Resident R73'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 resident's specific needs at the receiving facility. Review of the clinical record indicated Resident R169 was admitted to the facility on 4/10/24. Review of Resident R169's MDS dated 12/23/24, indicated diagnoses of high blood pressure, anemia (too little iron in the blood), and hip fracture. Review of Resident R169's clinical record revealed that the resident was transferred to the hospital on 12/2/24.	F 0622		

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F 0622 SS=E	Continued from page 46 Review of Resident R169'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 resident's specific needs at the receiving facility. Review of the clinical record indicated Resident R460 was admitted to the facility on 12/15/20. Review of Resident R460's MDS dated 2/14/24, indicated diagnoses of peripheral vascular disease (PVD, circulatory condition in which narrowed blood vessels reduce blood flow to the limbs), paranoid schizophrenia (a mental disorder characterized by delusions of persecution, grandiosity, or jealousy and by hallucinations, disorganized speech and behavior), and open wound on left foot.	F 0622		

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F 0622 SS=E	Continued from page 47 Review of Resident R460's clinical record revealed that the resident was transferred to another long-term care facility on 2/15/24. Review of Resident R460'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 resident's specific needs at the receiving facility Review of Closed Resident Record CR611's clinical record indicated the resident was admitted to the facility on 7/14/23. Review of Closed Resident Record CR611's MDS dated 11/13/24, indicated diagnoses of high blood pressure, dementia (group of symptoms that affects	F 0622		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395015	A. BLDG: __00_____ B. WING: _____	02/14/2025

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F 0622 SS=E	Continued from page 48 memory, thinking and interferes with daily life), and dysphagia (difficulty swallowing). Review of Closed Resident Record CR611s clinical record revealed that the resident was transferred to the hospital on 12/18/24. Review of Closed Resident Record CR611'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 resident's specific needs at the receiving facility. During an interview on 2/13/25, at 12:15 p.m. the Director of Nursing confirmed that the facility failed to make certain that the necessary resident information was communicated to the receiving health care provider for six of six residents as	F 0622		

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F 0622 SS=E	Continued from page 49 required. 28 Pa. Code 201.29 (a) (c.3) (2) Resident rights.	F 0622		
F 0641 SS=D		F 0641		

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F 0641 SS=D	Continued from page 50 483.20(g) Accuracy of Assessments §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by:	F 0641	1. Section J of annual MDS for R296 was corrected to reflect status as a current smoker. Section I6000 of MDS for R352 was corrected, removing schizophrenia as a current diagnosis. Section J1300 of the MDS for R381 was corrected to reflect current tobacco use. Section H0100A of the MDS for R413 was corrected to reflect that no indwelling catheter was utilized. Section A2105 of the MDS was corrected for R458 to reflect discharge home. MDS for CR611 section K0300 was corrected to reflect weigh loss. 2. Director or utilization review or designee will conduct an audit of all quarterly and annual assessments due for the month of February 2025 to ensure MDS assessments are coded accurately for the lookback period for tobacco use, weight loss, indwelling catheters, and schizophrenia. Discharge MDS for the month of February 2025 will be audited for correct discharge location. 3. Director of utilization review or	Completion Date: **03/10/2025** Status: **APPROVED** Date: **02/28/2025**

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F 0641 SS=D	Continued from page 51	F 0641	designee will in-service assessment coordinators on ensuring the accuracy of MDS assessments. 4. Director of utilization review will audit 5 residents MDS assessments weekly for 4 weeks, then 5 residents monthly for 2 months to ensure accuracy of sections I6000, J1300, H0100A, K0300 and A2105. Audit findings will be shared with QAPI committee.	

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F 0641 SS=D	Continued from page 52 Based on a review of facility policy and the RAI (Resident Assessment Instrument), clinical records, and staff interviews it was determined that the facility failed to make certain that resident assessments were accurate for six of 28 residents (Residents R296, R352, R381, R413, R458, and Closed Resident Record CR611). Findings include: Review of the facility policy "Resident Assessment/Minimum Data Set" dated 10/1/24, indicated the facility will conduct initially and periodically a comprehensive, accurate, and standardized reproducible assessment of each resident's functional capacity under the direction of a designated registered nurse. The Resident Assessment Instrument (RAI) User's Manual, which gives instructions for completing Minimum Data Set (MDS) assessments (periodic assessments of resident care needs), dated October 2024, indicated the following:	F 0641		

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F 0641 SS=D	Continued from page 53 - Section A2105: Discharge Status: This item documents the location to which the resident is being discharged at the time of discharge. Select the two-digit code that corresponds to the resident's discharge status. Code 01, Home/Community: if the resident was discharged to a private home, apartment, board and care, assisted living facility, group home, transitional living, or adult foster care. A community residential setting is defined as any house, condominium, or apartment in the community, whether owned by the resident or another person. - Section H0100 Appliances check all that apply in the past seven days A. Indwelling catheter. - Section J1300 Current Tobacco Use: code 1, yes if the resident or any other source indicates that the resident used tobacco in some form during the look-back period. - Section K0300 Weight Loss: code 2, yes if the resident has experienced a weight loss of 5% or more in the past 30 days or 10% or more in the last 180 days, and the weight loss was not planned and prescribed by a physician.	F 0641		

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F 0641 SS=D	Continued from page 54 Review of the clinical record indicated Resident R296 was admitted to the facility on 5/30/23. Review of Resident R296's clinical record revealed diagnoses of high blood pressure, malnutrition (lack of sufficient nutrients in the body), and Post Traumatic Stress Disorder (PTSD - a disorder in which a person has difficulty recovering after experiencing or witnessing a terrifying event and may have triggers that can bring back memories of trauma accompanied by intense emotional and physical reactions). Review of a physician order dated 10/14/24, indicated Resident R296 was OK for supervised smoking - does not need smoking apron. Review of Resident R296's care plan dated 2/29/24, indicated the resident does not need smoking apron when smoking and the resident will smoke in designated are with staff supervision. Review of Resident R296's annual MDS dated	F 0641		

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F 0641 SS=D	Continued from page 55 11/2/24, Section J - Health Conditions, Question J1300 indicated the resident was coded "0" No for Current Tobacco Use. During an interview on 2/14/25, at 11:49 a.m. Licensed Practical Nurse Assessment Coordinator (LPNAC) Employee E12 stated, "Residents will have a smoking order and we check the order and the care plan. It should be checked yes on the MDS if they are a current smoker." During an interview on 2/14/25, at 11:49 a.m. LPNAC Employee E12 confirmed that the facility failed to make certain that resident assessments were accurate for Resident R296. Review of Resident R352's admission record indicated he was originally admitted on 3/8/23. Review of Resident R352's MDS assessment dated 11/27/24, indicated he had diagnoses that included bipolar disorder (a disorder associated with episodes of mood swings ranging from depressive	F 0641		

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F 0641 SS=D	Continued from page 56 lows to manic highs), dementia (a condition characterized by memory loss and progressive or persistent loss of intellectual functioning), history of alcohol abuse and anxiety disorder (a medical condition creating a sense of acute fear, restlessness, and worry). Review of Resident R352's MDS assessment dated 11/27/24, Section I6000-Active diagnoses/psychiatric disorders indicated an "x" next to Schizophrenia. Review of Resident R352's Certified Registered Nurse Practitioner (CRNP) note dated 5/14/24, did not include a diagnosis of schizophrenia on the evaluation. Review of Resident R352's Certified Registered Nurse Practitioner (CRNP) note dated 9/30/24, did not include a diagnosis of schizophrenia on the evaluation. Review of Resident R352's care plans dated	F 0641		

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F 0641 SS=D	Continued from page 57 1/10/25, did not include a diagnosis of schizophrenia. During an interview on 2/12/25, at 10:39 a.m. LPNAC Employee E12 confirmed that the facility failed to make certain that Resident R352 MDS assessment and diagnoses were accurate as required. Review of the clinical record indicated Resident R381 was admitted to the facility on 11/7/23. Review of Resident R381's MDS dated 12/10/24, indicated diagnoses of high blood pressure, anxiety (a feeling of worry, nervousness, or unease), and overactive bladder. Review of a physician order dated 2/28/24, indicated Resident R381 was OK for supervised smoking - must wear apron when smoking. Review of Resident R381's care plan dated 2/27/24, indicated resident will smoke in designated	F 0641		

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F 0641 SS=D	Continued from page 58 are under staff supervision and resident will use smoking apron when actively smoking. Review of Resident R381's annual MDS dated 11/14/24, Section J - Health Conditions, Question J1300 indicated the resident was coded "0" No for Current Tobacco Use. During an interview on 2/14/25, at 11:49 a.m. LPNAC Employee E12 stated, "Residents will have a smoking order and we check the order and the care plan. It should be checked yes on the MDS if they are a current smoker." During an interview on 2/14/25, at 11:49 a.m. LPNAC Employee E12 confirmed that the facility failed to make certain that resident assessments were accurate for Resident R381. Review of the admission record indicated Resident R413 admitted to the facility on 7/10/24. Review of Resident R413's MDS dated 1/24/25,	F 0641		

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F 0641 SS=D	Continued from page 59 indicated the diagnoses of schizophrenia (a disorder that affects a person's ability to think, feel, and behave clearly), hypotension (low blood pressure), and septicemia (a life-threatening condition where bacteria enter the bloodstream and spread throughout the body). Section H indicated yes to indwelling catheter. Review of Resident R413's current physician orders failed to include an order for indwelling catheter. Review of Resident R413's care plan dated 1/23/25, failed to include indwelling catheter or management of. Observation on 2/14/25, at 10:00 a.m. Resident R413 was in bed and an indwelling catheter was not observed. Interview on 2/14/25, at 10:00 a.m. Resident R413 indicated "I've never had an indwelling catheter for my urine, it was collecting fluid from stomach, so I didn't vomit".	F 0641		

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F 0641 SS=D	Continued from page 60 Interview on 2/14/25, at 2:30 p.m. LPNAC Employee E12 confirmed the indwelling catheter was coded incorrectly and that Resident R413 did not have an indwelling catheter. Review of the admission record indicated Resident R458 was admitted to the facility on 11/15/23. Review of Resident R458's MDS dated 11/18/24, indicated the diagnoses of multiple sclerosis (a disease that affects central nervous system), repeated falls, and nicotine dependence. Section A2105 was entered as 04, which indicated that resident R91 was discharged to a Short-Term General Hospital. Review of a physician's order dated 11/15/24, indicated that Resident R458 was to be discharged to home on 11/18/24. During an interview on 2/13/25, at 12:42 p.m. RNAC Employee E28 confirmed the facility failed	F 0641		

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F 0641 SS=D	Continued from page 61 to make certain that resident assessments were accurate for Resident R458. Review of Closed Resident Record CR611's clinical record indicated the resident was admitted to the facility on 7/14/23. Review of Closed Resident Record CR611's MDS dated 11/13/24, indicated diagnoses of high blood pressure, dementia (a group of symptoms that affects memory, thinking and interferes with daily life), and dysphagia (difficulty swallowing). Section K - Swallowing/Nutritional Status, Question K0300: Weight Loss was coded "0" no or unknown for a loss of 5% or more in the last month or a loss of 10% or more in the last 6 months. Review of Closed Resident Record CR611's "Weights and Vitals Summary" revealed the following documented weights: - 11/4/24: 137.2 pounds, a loss of 5.95% in one month and a loss of 21.13% in six months - 10/1/24: 146.1 pounds	F 0641		

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F 0641 SS=D	Continued from page 62 - 9/4/24: 151.7 pounds - 8/1/24: 157.4 pounds - 7/2/24: 166.1 pounds - 6/2/24: 172.5 pounds - 5/1/24: 174.2 pounds During an interview on 2/14/25, at 10:54 a.m. Registered Dietitian Employee E11 stated that Closed Resident Record CR611's MDS should have been coded as "yes" for weight loss, stating, "It was probably a typo." During this interview, Registered Dietitian Employee E11 confirmed that the facility failed to make certain that resident assessments were accurate for Closed Resident Record CR611. Interview with the Director of Nursing on 2/14/25, at 3:00 p.m. confirmed the facility failed to make certain that resident assessments were accurate for six of 28 residents (Residents R296, R352, R381, R413, R458, and Closed Resident Record CR611).	F 0641		

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F 0641 SS=D	Continued from page 63 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 211.5(f) Clinical Records 28 Pa. Code: 211.12(d)(1)(2)(3)(5) Nursing services.	F 0641		
F 0684 SS=D		F 0684		

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F 0684 SS=D	Continued from page 64 483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by:	F 0684	1. R213 physician orders are plan of care were updated to reflect use of continuous glucose monitoring device. R436 had leg dressings changed on 2/10/2025. Care plan for R436 was updated to reflect diagnosis of cellulitis. R812 had dressings changed on 2/10/2025. Policy has been developed for personal use of continuous glucose monitoring. 2. An audit was conducted of wound dressings on 2/10/2025 to ensure all dressings were completed according to physician order. No additional issues identified. An audit was conducted of residents utilizing continuous glucose monitoring. No additional issues identified. 3. Director of nursing or designee will in-service licensed staff on completing treatments as ordered, and ensuring residents who utilize continuous glucose monitoring devices have physician orders and plan of care for care of device and components. 4. Director of nursing or designee will audit 5 residents twice weekly	Completion Date: **03/10/2025** Status: **APPROVED** Date: **02/28/2025**

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F 0684 SS=D	Continued from page 65	F 0684	for 2 weeks, then 5 residents weekly for 2 weeks, then 5 residents monthly for 2 months to ensure treatments are completed as ordered. Director of nursing or designee will audit new admissions for 30 days to ensure residents with orders for continuous glucose monitoring have appropriate orders and care plan. Audit findings will be shared with QAPI committee.	

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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F 0684 SS=D	Continued from page 66 Based on review of facility policy, clinical records, resident and staff interview it was determined that the facility failed to follow physician orders for wound care for two of four residents (Resident R436, and R812), failed to monitor a CGM (continuous glucose monitoring device), obtain physician orders for continuous monitoring of results, and failed to have a care plan for care and management of the device for one of three residents with special devices (Resident R213). Findings include: Review of the facility policy "Wound Care" dated 10/1/24, indicated the facility follows physician's orders to maintain the highest level of comfort and promote healing of wounds. Interview with the Director of Nursing on 2/13/25, at 2:00 p.m. indicated the facility did not have a policy for CGM. Review of the admission record indicated Resident	F 0684		

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F 0684 SS=D	Continued from page 67 R436 was admitted on 1/22/25. Review of Resident R436's Minimum Data Set (MDS - a periodic assessment of care needs) dated 2/2/25, indicated the diagnoses of cellulitis (a bacterial infection of the skin and underlying tissues), anxiety (intense, excessive, and persistent worry and fear about everyday situations), and paranoid personality disorder (PPD - a mental health condition characterized by a long-term pattern of extreme distrust and suspicion of others). Review of Resident R436's physician order dated 1/29/25, indicated wound care to bilateral (both sides) lower extremities, cleanse with soap and water, apply triple antibiotic ointment wrap in gauze and secure with tape. Review of Resident R436's care plan dated 1/23/25, failed to include a plan for management and care of cellulitis. Observation on 2/10/25, at 10:00 a.m. Resident	F 0684		

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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F 0684 SS=D	Continued from page 68 R436 was sitting on the side of the bed with feet dangling. The dressings on the left leg indicated 2/8/25, and the right leg dressing had no date. Interview on 2/10/25, at 10:00 a.m. Resident R436 indicated "My legs are sore and draining. I changed my right leg myself this morning because it was so wet. They changed the other leg the other day. Nobody did my legs yesterday." Review of Resident R436's Treatment Administration Record (TAR) indicated the treatments were administered on 2/9/25. Review of Resident R436's Nurse Practitioner note dated 2/10/25, indicated bilateral lower extremity stasis color changes equal in appearance, with dry cracked skin to the right lower extremity, with increased erythema (redness) and seeping yellow/green drainage, warm to touch. Interview on 2/10/25, at 10:05 a.m. Unit Director Registered Nurse (RN) Employee E6 confirmed the	F 0684		

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F 0684 SS=D	Continued from page 69 dressing on the left leg was dated 2/8/25, and should have been changed on 2/9/25, and the TAR indicated it was completed when it was not. Review of the admission record indicated Resident R812 was re-admitted to the facility on 2/7/25, with diagnosis that included angina pectoris (chests pain caused by reduced blood flow to the heart), cardiomyopathy (disease of the heart that makes it hard for the heart to deliver blood to the body), intracardiac thrombosis (blood clot in the heart's chambers). Observation on 2/10/25, at 9:30 a.m. Resident R812 was sitting on bed, with dressing to right foot dated 2/8/25, and dressing to right arm dated 2/8/25. Review of Resident R812's physician order dated 2/8/25, indicated right wrist, cleanse with normal saline, apply betadine (antiseptic) soaked gauze & cover with dry dressing one time a day for wound care. Right toes, cleanse with normal saline, apply	F 0684		

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F 0684 SS=D	Continued from page 70 betadine-soaked gauze & cover with dry dressing one time a day for wound care. Review of Resident R812's care plan dated 2/9/25, indicated to administer treatments as ordered. Interview with resident R812 on 2/10/25, at 9:30 a.m. indicated nobody changed his dressings yesterday, 2/9/25. Interview on 2/10/25, at 10:05 a.m. Unit Director RN Employee E6 confirmed the dressing on the right leg and right arm were dated 2/8/25, and should have been changed on 2/9/25. Review of the admission record indicated Resident R 213 admitted to the facility on 6/11/24. Review of the Resident R213's MDS dated 11/2/24, indicated the diagnoses of anemia (the blood doesn't have enough healthy red blood cells), heart failure (heart doesn't pump blood as well as it should), and diabetes (a long-term condition in	F 0684		

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F 0684 SS=D	Continued from page 71 which the body has trouble controlling blood sugar and using it for energy). Review of Resident R213's physician order dated 11/14/24, indicated change Dexcom device (CGM) every 15 days, family provides supplies for monitoring. Review of Resident R213's care plan failed to include a plan of care for the Dexcom monitoring and management. Observation of Resident R213 on 2/10/15, at 12:40 p.m. indicated resident in her wheelchair with her cell phone on the overbed table. Interview with Resident R213 on 2/10/25, at 12:40 p.m. indicated "I have a Dexcom in my left arm. It monitors my glucose and goes straight to my cell phone. When asked how the nurses would know if her phone alarmed high or low readings, she indicated the nurses wouldn't know because it rings on my phone. Some of the nurses know I have it	F 0684		

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F 0684 SS=D	Continued from page 72 and will ask to see my phone. Other nurses don't know I have it and they poke my finger for my sugar". Interview on 2/10/25, at 12:45 p.m. Unit Director RN Employee E19 verified the nurses don't monitor the Dexcom. It goes to Resident R213's phone, and if the device alarmed nursing staff would not be aware unless they were near resident's personal cell phone at the time of alarm. Interview on 2/14/25, at 3:00 p.m. the Director of Nursing confirmed the facility failed to follow physician orders for wound care for two of four residents (Resident R436, and R812), failed to monitor a CGM, obtain physician orders for continuous monitoring of results, and failed to have a care plan for care and management of the device for one of three residents with special devices (Resident R213). 28 Pa. Code: 201.14(a) Responsibility of licensee. 28 Pa. Code 201.18(b)(1) Management	F 0684		

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F 0684 SS=D	Continued from page 73 28 Pa. Code: 201.29(a)(d) Resident rights 28 Pa. Code: 211.10(c)(d) Resident care policies 28 Pa. Code 211.12(d)(1)(2)(3)(5) Nursing services	F 0684		
F 0688 SS=D	483.25(c)(1)-(3) Increase/Prevent Decrease in ROM/Mobility §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by:	F 0688	1. R113 plan of care was updated to include care relating to the use of a sling. 2. Director of nursing or designee will conduct a house audit of residents using slings to ensure plan of care includes care instructions related to the sling. 3. Director of nursing or designee will in-service license nurses on ensuring residents who utilize a sling have it included in their plan of care. 4. Director of nursing or designee will audit 3 residents weekly for 2 weeks, 2 residents weekly for 2 weeks, then 3 residents monthly for 2 months to ensure residents utilizing a sling have it included in their plan of care. Audit findings will be shared with QAPI committee.	Completion Date: **03/10/2025** Status: **APPROVED** Date: **02/28/2025**

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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F 0688 SS=D	Continued from page 74	F 0688		

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F 0688 SS=D	Continued from page 75 Based on facility policy, observation, clinical record review, and staff interview, it was determined that the facility failed to provide treatment and services to prevent further decrease in range of motion for one of three residents (Resident R113). Findings include: Review of the facility policy "Assistive Devices and Equipment" dated 10/1/24, indicated the facility maintains and supervises the use of assistive devices and equipment for residents. Staff are trained and demonstrate competency on the use of devices and equipment prior to assisting or supervising residents. Review of the facility policy "Pressure Ulcer Prevention" dated 10/1/24, indicated residents will receive skin care, repositioning and nutritional support to assist in preventing the development of avoidable pressure ulcers. Pressure can come from shearing, friction, splints, casts, bandages, and wrinkles in the bed linen.	F 0688		

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F 0688 SS=D	Continued from page 76 Review of the admission record indicated R113 was admitted to the facility on 1/16/25. Review of Resident R113's Minimum Data Set (MDS - a periodic assessment of care needs) dated 1/22/25, indicated the diagnoses of stroke (damage to the brain from an interruption of blood supply), anemia (the blood doesn't have enough healthy red blood cells), End Stage Renal Disease (ESRD - kidneys cease to function on a permanent basis leading to the need for a regular course of long-term dialysis or a kidney transplant to maintain life), and hip fracture (broken bone in hip). Review of Resident R113's physician order dated 1/27/25, indicated weight bearing as tolerated to left lower extremity, non-weight bearing to left upper extremity. Continue left arm sling when not exercising. Review of Resident R113's care plan dated 1/17/25, failed to include a plan for the sling, removal of, and/or skin assessments relating to the	F 0688		

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F 0688 SS=D	Continued from page 77 sling's use. Observation on 2/10/25, at 12:45 p.m. Resident R113 was observed in the dining room with a sling on the left arm. Interview on 2/10/25, at 12:50 p.m. Unit Director RN Employee E19 confirmed the orders did not define the removal of the sling, and/or skin assessments relating to the sling's use. Interview on 2/13/25, at 1:43 p.m. Assistant Director of Nursing (ADON) Employee E20 confirmed the facility the facility failed to provide treatment and services to prevent further decrease in range of motion for one of three residents (Resident R113). 28 Pa. Code: 201.29(j) Resident rights. 28 Pa. Code: 211.10(c)(d) Resident care policies. 28 Pa. Code: 211.12(d)(1)(2)(3)(5) Nursing services.	F 0688		

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F 0688 SS=D	Continued from page 78	F 0688		
F 0689 SS=J		F 0689		

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F 0689 SS=J	Continued from page 79 483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by:	F 0689	1. The facility submitted an immediate corrective action plan to on-site surveyors on 2/11/2025. 2. All residents in facility had updated elopement assessments completed on 2/11/2025. New admissions to facility are being audited daily to ensure elopement risk assessment is completed on admission. Facility policy on elopements was revised on 2/11/2025 to clarify what classifies a resident as being at risk for elopement. Elopement binder at reception desk was updated. 3. Staff in all departments were re-inserviced on completion of elopement assessments and identifying exit seeking behaviors by nursing administration team. Facility has contracted with Core Tactics to conduct on site directed in-servicing to all staff on 3/11/2025-3/12/2025 on recognizing elopement risks. 4. Director of nursing or designee will complete 30-day audit of all new admissions started on 2/12/2025 to ensure elopement risk assessments are complete and residents who are	Completion Date: **03/10/2025** Status: **APPROVED** Date: **03/03/2025**

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F 0689 SS=J	Continued from page 80	F 0689	at risk for elopement have care plan interventions in place to minimize the risk of successful elopement. Audit findings will be shared with QAPI committee.	

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F 0689 SS=J	Continued from page 81 Based on review of facility policy and documents, clinical records, and staff interviews, it was determined that the facility failed to make certain each resident received adequate supervision which resulted in an elopement (resident exits to an unsupervised or unauthorized area without the facility's knowledge) for one of two residents (Resident R456). This failure created an immediate jeopardy situation for one of two residents (Resident R456). Findings include: Review of the facility "Resident Elopement" policy last reviewed 10/1/24, indicated cognitively impaired residents at risk for elopement will be appropriately monitored to reduce the potential for injury. Elopement is defined as a resident leaving the physical structure of the facility without the knowledge of facility staff. Upon admission, residents will be assessed for elopement risk. Cognitively impaired residents with the physical ability to leave the facility without assistance, and	F 0689		

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F 0689 SS=J	Continued from page 82 who have demonstrated or vocalized a desire to leave the facility will be placed on a unit with an electronic monitoring system or similarly secured unit. In the event that a facility does not have an operational electronic monitoring system, the resident will be evaluated for transfer to a more appropriate facility that offers electronic monitoring. The resident and legally responsible person shall be notified of the facility recommendation. Interim safety monitoring measures shall be implemented pending transfer. Elopement risk will be care planned with individualized approaches to reduce the potential for elopement and/or to redirect the resident in the event that an elopement attempt is made. Review of the Resident Assessment Instrument 3.0 User's Manual effective October 2024, 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	F 0689		

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F 0689 SS=J	Continued from page 83 8-12: moderately impaired 0-7: severe impairment Review of Resident R456's admission record indicated he was admitted on 1/25/25. It was indicated the resident was admitted to the locked unit. Review of Resident R456's Minimum Data Set assessment (MDS -a periodic assessment of resident care needs) dated 2/1/25, included diagnoses of malignant neoplasm of brain (growth of cancerous cells in the brain), metabolic encephalopathy (change in how your brain works due to an underlying condition), and mood disorder due to physiological condition. Review of Section C0500-BIMS screening indicated a score of "10," which indicated Resident R456 was moderately impaired. Review of Resident R456's admission Elopement Risk Assessment dated 1/25/25, revealed the assessment was left blank and not completed,	F 0689		

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F 0689 SS=J	Continued from page 84 however it indicated the resident was not at risk for elopement. The facility failed to complete and accurately identify Resident R456 as an elopement risk. Review of a progress note dated 1/27/25, at 10:25 a.m. stated the resident was irate, requested to be discharged and refused to sign the admission packet. The facility failed to complete an elopement risk assessment for Resident R456. Review of a progress note dated 1/27/25, at 11:58 a.m. entered by Social Worker, Employee E23 indicated the resident was in jail when he had a change in condition which led to hospitalization. It was indicated he was in jail for drug related charges. The resident had brain surgery. It was indicated the resident's discharge plan was to a facility that specialized in cognitive therapy. Review of a progress note dated 1/27/25, at 10:56 p.m. indicated Resident R456 stated it's wrong what you all are doing to me, I should be home. Resident	F 0689		

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F 0689 SS=J	Continued from page 85 began to ask when he was going to be discharged. The facility failed to complete an elopement risk assessment for Resident R456 after he displayed exit seeking behaviors. Review of Resident R456's psychiatric evaluation dated 1/28/25, indicated the resident was memory impaired and had difficulty with short term recall. His insight, judgement, and impulse control was poor. The resident was displaying severe agitation placing him at risk for harming himself and others. It was stated "patients with brain injuries are periodically unable to restrain impulses that result in verbal or physical aggression." Review of Resident R456's smoking assessment dated 2/2/25, indicated the resident does not have cognitive loss. The facility failed to accurately assess Resident R456 for safe smoking. It was indicated the resident was safe to smoke with direct supervision. Review of Resident R456's physician order dated	F 0689		

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F 0689 SS=J	Continued from page 86 2/2/25, indicated the resident may go on a leave of absence with a responsible party or escort. Review of information submitted to the Department of Health on 2/3/25, indicated Resident R456 was unable to be located. A search of the facility was conducted and police were notified. During an interview with his roommate it was indicated Resident R456 was talking about leaving to get his check. The facility was notified Resident R456 was back in Pittsburgh at a friend's house. Resident R456 returned to the facility on 2/4/25, and discharged against medical advice. Review of a progress note dated 2/3/25, at 8:35 p.m. entered by the Director of Nursing (DON) indicated the police were on site, a preliminary search of immediate area was done, and the resident was not located. Review of progress note dated 2/3/25, entered by Unit Manager, Licensed Practical Nurse, Employee E13 indicated a nurse notified her at 7:30 p.m. that	F 0689		

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F 0689 SS=J	Continued from page 87 Resident R456 was not able to be located. It was indicated the DON and police were notified. The facility contacted the resident's family member around 9:00 p.m. and the resident's family member informed staff Resident R456 was seen in Pittsburgh. During an interview on 2/10/25, at 9:52 a.m. Unit Manager LPN, Employee E27 stated elopement risk assessments are completed upon admission, and residents are reassessed if the resident displays exit seeking behaviors. It was indicated typically wander guards are applied, and if the resident refuses, then the doctor is notified, and it is documented in the clinical record. Staff are to monitor the resident. During an interview on 2/10/25, at 11:04 a.m. LPN Employee E26 stated Resident R456 was pretty defiant, difficult to redirect, anxious and wanted to leave. It was indicated Resident R456 had an order for a leave of absence to go smoke. LPN, Employee E26 stated someone was always with him	F 0689		

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F 0689 SS=J	Continued from page 88 when he left the unit, or he could go to the outdoor pavilion located on 2 West. Review of the facility's investigation for Resident R456's elopement on 2/10/25, at 12:30 p.m., revealed Resident R456 signed himself out on 2/3/25, sometime between 1:41 p.m. and 1:47 p.m. The section for who the resident was escorted by was left blank. No witness statements were obtained. During an interview on 2/10/25, at 12:54 p.m., the DON indicated video surveillance revealed Resident R456 getting on a bus at 2:08 p.m. on 2/3/25. It was indicated the resident's roommate said Resident R456 stated he was going to smoke after lunch, and he never returned. The DON confirmed Resident R456 was not escorted to supervised smoking on 2/3/25. The DON stated he was allowed off the unit. The DON confirmed the facility failed to complete an elopement assessment upon admission and failed to reassess Resident R456 when he displayed exit-seeking behaviors. The DON	F 0689		

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F 0689 SS=J	Continued from page 89 confirmed the facility failed to accurately complete Resident R456's smoking assessment. During an interview on 2/10/25, at 1:50 p.m. Nurse Aide, Employee E30 stated on 2/3/25, she worked 7 a.m. until 11 p.m. It was indicated when Resident R456 was admitted he was very confused, very agitated, and aggressive. "His whole demeanor was not wanting to be here." NA, Employee E30 stated the unit Resident R456 was on, is a completely locked down unit. NA, Employee E30 stated she has been working on that unit for five years and just in her opinion she doesn't think residents should be allowed off the unit unattended to smoke. It was indicated Resident R456's family member was the first to take him off the unit to smoke and NA, Employee E30 stated staff on the unit are not responsible to take residents to smoke. NA, Employee E30 stated it was questioned what staff should do when the resident's brother isn't available to take the resident to smoke. It was indicated he was let off the unit by the supervisor and he returned to the unit the first time, however the second time he	F 0689		

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F 0689 SS=J	Continued from page 90 did not. During an interview on 2/10/25, at 2:02 p.m. LPN, Employee E26 stated she worked 7 a.m. until 3 p.m. on 2/3/25. It was indicated the last time she seen Resident R456 was on 2/3/25, sometime after lunch and he wanted a cigarette. LPN, Employee E26 stated she did not see him get on the elevator and didn't know he left. It was indicated Resident R456 recently received an order for an LOA (leave of absence) and he signed a smoking contract with RN, Employee E27. During an interview on 2/10/25, at 2:22 p.m. Unit Manager, LPN Employee E13 indicated she worked 3 p.m. until 11 p.m. on 2/3/25. It was indicated she only became familiar with Resident R456 after he eloped. She indicated his short-term memory was not so good and it was her understanding staff were letting him off the unit to smoke. Unit Manager, LPN E13 stated she never seen Resident R456 on 2/3/25, and was notified by staff around 7 p.m. that he was not on the unit and	F 0689		

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F 0689 SS=J	Continued from page 91 missing. It was indicated dinner was served around 5 p.m. and staff failed to realize Resident R456 was missing then. Unit Manager, LPN, Employee E13 stated Resident R456 was not identified as an elopement risk, so no interventions were in place. During an interview on 2/10/25, at 2:32 PM, NA Employee E33 stated she worked 7 a.m. until 7 p.m. on 2/3/25, and was not assigned Resident R456. It was indicated the few interactions she had with Resident R456, he was aggressive and combative. It was indicated he verbally expressed that he did not want to be at the facility. She indicated she heard him talking about smoking, but she did not know residents on the locked unit had privileges to go smoke. It was indicated the last time she seen him was after lunch and he was getting irate about wanting to smoke a cigarette. NA, Employee E33 stated "I would never" let a resident off the locked unit unattended, "first of all it's a locked down unit, I don't know much about him, but he's on the locked unit for a reason."	F 0689		

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F 0689 SS=J	Continued from page 92 On 2/11/25, at 10:13 a.m. the NHA and DON were notified that Immediate Jeopardy was called due to the elopement of Resident R456 on 2/3/25, and facility staff were provided an Immediate Jeopardy template, and a corrective action plan was requested. On 2/11/25, at 3:07 p.m. an immediate action plan was received and accepted which included the following interventions: 1. The facility made contact with R456 and family who returned to the facility and signed out of the facility Against Medical Advice. Facility will reassess all residents for elopement risk by 2/11/25. Assessments will be confirmed completed on 2/11/25. 2. All residents assessed to be at risk of elopement will have care plan and interventions implemented to reduce the risk of successful elopement by 2/11/25. Residents being housed on east side locked units who are not identified as needing a locked unit will	F 0689		

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F 0689 SS=J	Continued from page 93 have a physician order permitting them to leave unit unsupervised. 3. Administrator and Director of Nursing will review facility elopement policy and revise as necessary by 2/11/25. 4. All facility staff will be re-in serviced on elopement policy and identifying exit seeking behaviors upon arrival for next scheduled shift. Any staff not scheduled to work prior to 2/12/25, will be contacted by telephone by 2/12/25, to receive education. 5. Director of nursing will audit all new admissions for 30 days to ensure elopement risk assessment is complete and newly admitted residents who are at risk for elopement have care plan interventions in place to reduce the risk of successful elopement. 6. Policy revision, staff education and ongoing audits will be shared QAPI committee.	F 0689		

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F 0689 SS=J	Continued from page 94 Elopement policy was reviewed and revised on 2/11/25. During a phone interview on 2/12/25, at 9:54 a.m. RN, Employee E32 stated she was assigned Resident R456 on 2/3/35. It was indicated she was told the Unit Manager allowed Resident R456 to go off the unit to smoke, and was unsure when he left that day. She indicated she was unsure what interventions were in place for him and that "he's new" so it depended on whatever the Unit Manager allowed. During in-person interviews completed from 2/12/25, at 12:20 p.m. until 2/12/25, at 2:16 p.m. 58/58 staff confirmed they were educated. Staff were educated on how and when to complete an elopement assessment, and what to do for residents that are displaying exit seeking behaviors. Staff were educated on the updated elopement policy. During phone interviews completed on 2/13/25, at 10:19 a.m. 9 of 9 staff members confirmed they were educated on elopement risks. All staff must confirm	F 0689		

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F 0689 SS=J	Continued from page 95 they were educated prior to the start of their next shift and sign the education sheet in-person. 430 of 430 staff were educated. On 2/13/25 at 10:17 a.m., all residents' assessments for elopement risk were reviewed and found to be completed, and care plans were reviewed and updated if needed for 461 of 461 residents. Review of 8/130 Residents who resided on the locked unit had a physician order permitting them to leave the unit unsupervised. Staff education was verified with dated sign-in sheets and review of all current staff and agency staff utilized in the facility having signed and/or educated over the phone as indicated. On 2/13/25, the facility completed an audit of residents who were newly admitted as of 2/11/25. Daily audits will be completed by DON or designee for next 30 days to ensure an elopement risk assessment was completed.	F 0689		

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F 0689 SS=J	Continued from page 96 The facility's next QAPI meeting is scheduled for 2/27/25. Verification of the facility's Corrective Action Plan revealed all elements of plan were met. The Immediate Jeopardy was lifted on 2/13/25, at 11:13 a.m. During an interview on 2/14/25, at 2:45 p.m., the Nursing Home Administrator and Director of Nursing confirmed that the facility failed to provide adequate supervision resulting in Resident R456's elopement. This failure created an immediate jeopardy situation for Resident R456 and potentially put him at risk of harm or injury. 28 Pa. Code 201.14(a) Responsibility of Licensee. 28 Pa. Code 201.18 (e)(1)(3) Management. 28 Pa. Code 211.10(c)(d) Resident care policies. 28 Pa. Code 211.12 (c)(d)(3)(5) Nursing services.	F 0689		

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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
F 0689 SS=J	Continued from page 97	F 0689		
F 0690 SS=D	483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as	F 0690	1. Physician orders were obtained for irrigation of suprapubic catheter for R367. Plan of care was updated to reflect irrigation orders. 2. Director of nursing or designee will conduct a house audit of residents with suprapubic catheters to ensure orders for irrigation are present and reflected in the plan of care. 3. Director of nursing or designee will in-service licensed nurses on ensuring physician orders for irrigation of suprapubic catheters are obtained on admission and reflected in the plan of care. 4. Director of nursing or designee will audit 2 residents with supra pubic catheters weekly for 3 weeks to ensure physician orders and care plan are present. Audit findings will be shared with QAPI committee.	Completion Date: **03/10/2025** Status: **APPROVED** Date: **02/28/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395015	A. BLDG: __00_____ B. WING: _____	02/14/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
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F 0690 SS=D	Continued from page 98 much normal bowel function as possible. This REQUIREMENT is not met as evidenced by:	F 0690		

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F 0690 SS=D	Continued from page 99 Based on facility policy, clinical record review, and interview, the facility failed to ensure that appropriate physician orders were obtained for residents with a supra-pubic catheter (a medical device that drains urine from the bladder directly through the abdominal wall), and failed to maintain catheter irrigation equipment for one of three residents (Resident R367). Findings include: Review of the facility policy "Catheter Irrigation" (flushing of the catheter and bladder with a sterile solution) dated 10/1/24, indicated the purpose is to cleanse and maintain a patent (open) catheter. Irrigate according to physician's order. Review of the clinical record indicated Resident R367 was admitted to the facility on 9/19/24. Review of Resident R367's Minimum Data Set (MDS - a periodic assessment of care needs) dated 2/2/25, indicated diagnoses of neurogenic bladder	F 0690		

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F 0690 SS=D	Continued from page 100 (lack of bladder control due to a brain, spinal cord or nerve problem), paraplegia (paralysis of legs and lower body), and depression. Review of Resident R367's current physician orders failed to include orders for care and management of the suprapubic catheter and irrigation of. Review of Resident R367's current care plan indicated resident has suprapubic catheter related to neurogenic bladder. Monitor and report to physician signs and symptoms of infection, and to change the catheter as needed for blockage. Observation on 2/10/25, at 1:30 p.m. Resident R367 was positioned in bed with supra-pubic catheter and drainage bag on bed frame. The urine was thick with sediment (a solid material) visualized in tubing. The bedside table had an irrigation syringe kit labeled "catheter" which was dated 2/8/25. Interview and tour on 2/10/25, at 1:35 p.m. with Unit Manager Registered Nurse (RN) Employee E6	F 0690		

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F 0690 SS=D	Continued from page 101 confirmed Resident R367 was positioned in bed with supra-pubic catheter and drainage bag on bed frame. The urine was thick with sediment (a solid material) visualized in tubing. The bedside table had an irrigation syringe kit labeled "catheter" which was dated 2/8/25. Also indicated the physician orders "must have fallen off, when he was out to the hospital" and he currently did not have any orders relating to the supra-pubic catheter and irrigation of. Interview on 2/14/25, at 3:00 p.m. the Director of Nursing confirmed the facility failed to ensure that appropriate physician orders were obtained for residents with a supra-pubic catheter, and failed to maintain catheter irrigation equipment for one of three residents (Resident R367). 28 Pa. Code 201. 18(b)(1) Management. 28 Pa code:211.10(c)(d) Resident care policies. 28 Pa Code:211.12(a)(c)(d)(1)(2)(5) Nursing services.	F 0690		

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F 0690 SS=D	Continued from page 102	F 0690		
F 0691 SS=D	483.25(f) Colostomy, Urostomy, or Ileostomy Care §483.25(f) Colostomy, urostomy,, or ileostomy care. The facility must ensure that residents who require colostomy, urostomy, or ileostomy services, receive such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences. This REQUIREMENT is not met as evidenced by:	F 0691	1. Physician orders were obtained for care of ostomy for R367. Plan of care was updated to reflect physician orders. 2. Director of nursing or designee will conduct a house audit of residents with ostomies to ensure orders are present and reflected in the plan of care. 3. Director of nursing or designee will in-service licensed nurses on ensuring physician orders for ostomy care are obtained on admission and reflected in the plan of care. 4. Director of nursing or designee will audit 2 residents with ostomies weekly for 3 weeks to ensure physician orders and care plan are present. Audit findings will be shared with QAPI committee.	Completion Date: **03/10/2025** Status: **APPROVED** Date: **02/28/2025**

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F 0691 SS=D	Continued from page 103 Based on facility policy review, clinical record review, resident, and staff interviews, it was determined that the facility failed to obtain colostomy (a surgical operation in which a piece of the colon is diverted to an artificial opening in the abdominal wall so as to bypass a damaged part of the colon) care and management physician orders consistent with professional standards of practice for one of five residents reviewed (Resident R367). Findings include: Review of the Code of Federal Regulations (CFR) §483.25(f) Colostomy, urostomy, or ileostomy care. The facility must ensure that residents who require colostomy, urostomy, or ileostomy services, receive such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences. Review of the facility policy "Colostomy Care" dated 10/1/24, indicated the purpose is to provide	F 0691		

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F 0691 SS=D	Continued from page 104 guidelines that will aid in preventing exposure of the resident's skin to fecal matter (stool). Review of the clinical record indicated Resident R367 was admitted to the facility on 9/19/24. Review of Resident R367's Minimum Data Set (MDS - a periodic assessment of care needs) dated 2/2/25, indicated diagnoses of neurogenic bladder (lack of bladder control due to a brain, spinal cord or nerve problem), paraplegia (paralysis of legs and lower body), and depression. Review of Resident R367's current physician orders failed to include orders for care and management of the colostomy. Review of Resident R367's current care plan indicated resident has a colostomy for bowel diversion. Resident will have functioning colostomy and maintain skin integrity through next review date. Observation on 2/10/25, at 1:30 p.m. Resident	F 0691		

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F 0691 SS=D	Continued from page 105 R367 was positioned in bed covered in a blanket. Interview on 2/10/25, at 1:30 p.m. Resident 367 indicated he has a colostomy on his abdomen. Interview and tour on 2/10/25, at 1:35 p.m. with Unit Manager Registered Nurse (RN) Employee E6 confirmed Resident R367 has a colostomy and that the physician orders failed to include care and management of it. Interview on 2/14/25, at 10:39 a.m. the Director of Nursing confirmed the facility failed to obtain colostomy care and management physician orders consistent with professional standards of practice for one of five residents reviewed (Resident R367). 28 Pa. Code: 201.18 (b) (1) (e) (1) Management. 28 Pa. Code: 211.10(c)(d) Resident care policies. 28 Pa. Code: 211.12(d)(1)(5) Nursing services.	F 0691		

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F 0693 SS=D	483.25(g)(4)(5) Tube Feeding Mgmt/Restore Eating Skills §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by:	F 0693	1. Feeding bottle and flush bag for R379 was changed and labeled with hang date and time. 2. A house audit was done of residents with tube feeding was done to ensure all feeding bottles and flush bags were dated and timed. No additional issues identified. 3. Director of nursing or designee will in-service licensed nursing staff to ensure tube feeding and supplies are dated and timed upon hanging. 4. Director of nursing or designee will audit 3 residents with tube feeding weekly for 2 weeks, then 2 residents weekly for 2 weeks, then 3 residents monthly for 2 months to ensure date and time are present on feeding bottle and flush bags. Audit findings will be shared with QAPI committee.	Completion Date: **03/10/2025** Status: **APPROVED** Date: **02/28/2025**

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F 0693 SS=D	Continued from page 107 Based on review of facility policy, clinical record review, observation, and staff interview, it was determined that the facility failed to ensure that residents with an enteral feeding tube (a tube inserted in the stomach through the abdomen) received appropriate treatment and services to prevent potential complications for one of three residents (Residents R379). Findings include: Review of Resident R379's clinical record indicated the resident was admitted to the facility on 5/13/24. Review of Resident R379's Minimum Data Set (MDS - a periodic assessment of care needs) dated 11/4/24, indicated diagnoses of high blood pressure, cerebral infarction (necrotic tissue in the brain resulting loss of blood and oxygen to the brain), and dysphagia (difficult swallowing). MDS section K-Swallowing/Nutritional Status K0520 indicated a feeding tube.	F 0693		

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F 0693 SS=D	Continued from page 108 Review of current physician order indicated Osmolite 1.2 (a type of feeding that will supply a person with nutrients and minerals) to be administered continual over 24 hours. Flush tube with 30 ml of warm water every hour. During a tour of unit on 2/10/25, at 12:00 p.m. Resident R379's enteral feeding and water flush bag was observed hanging at bedside and failed to have a date written on the enteral feeding bottle or the water flush bag. During an interview on 2/10/25, at 12:37 p.m. Licensed Practical Nurse (LPN) Employee E13 confirmed she did not see a date on the enteral feeding bottle and the water flush bag. During an interview on 2/10/25, at 3:00 p.m. the Director of Nursing confirmed that the facility failed to ensure that residents with an enteral feeding tube received appropriate treatment and services to prevent potential complications for one of three residents (Residents R379).	F 0693		

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F 0693 SS=D	Continued from page 109 28 Pa. Code: 201.18(b)(1) Management. 28 Pa. Code: 211.10(c) Resident care policies. 28 Pa. Code: 211.12(d)(1) Nursing services.	F 0693		
F 0694 SS=D		F 0694		

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F 0694 SS=D	Continued from page 110 483.25(h) Parenteral/IV Fluids § 483.25(h) Parenteral Fluids. Parenteral fluids must be administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences. This REQUIREMENT is not met as evidenced by:	F 0694	1. R229 midline dressing was changed. Midline was discontinued 2/17/2025. 2. Director of nursing or designee will conduct a house audit of residents with intravenous lines to ensure orders for dressing changes are present and being followed. 3. Director of nursing or designee will in-service licensed staff on ensuring orders for weekly midline and PICC line dressing changes are followed, dressings are dated when done, and care plan interventions are present for care of intravenous lines. 4. Director of nursing or designee will audit 3 residents with midlines or PICC lines weekly for 2 weeks, then 2 resident weekly for 2 weeks, then 2 residents monthly for 2 months to ensure orders for dressing changes are present and being followed, and insertion site dressings are dated and care of lines are reflected in the plan of care. Audit findings will be shared with QAPI committee.	Completion Date: **03/10/2025** Status: **APPROVED** Date: **03/03/2025**

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F 0694 SS=D	Continued from page 111 Based on review of policy and clinical records, staff and resident interview, it was determined that the facility failed to ensure that physician's orders were followed for the care of an IV Midline Catheter (a type of long-term intravenous catheter) for one of three residents reviewed (Resident R229). Findings include: Review of facility policy "Intravenous access: Dressing Change" dated 10/1/24, indicated the purpose is to prevent complications associated with intravenous therapy, including catheter-related infections associated with contaminated, loosened or soiled catheter site dressings. Perform site care and dressing change at established intervals or immediately if the integrity of the dressing is compromised (e.g., damp, loosened or visibly soiled). Review of the admission record indicated Resident R229 was admitted to the facility on 12/5/24.	F 0694		

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F 0694 SS=D	Continued from page 112 Review of Resident R229's Minimum Data Set (MDS - a periodic assessment of care needs) dated 2/5/25, indicated the diagnoses of seizure disorder (a person experiences abnormal behaviors, symptoms and sensations, sometimes including loss of consciousness), osteomyelitis (inflammation of bone caused by infection) right ankle and foot, and spina bifida (a birth defect where the spinal cord fails to develop or close properly while in the womb). Review of Resident R229's physician order dated 1/31/25, indicated IV Midline - monitor site every shift for signs and symptoms of infection. Transparent dressing changes on admission, weekly, and as needed thereafter. Review of the Resident R229's current care plan failed to include a plan for care and management of the IV midline catheter. Review of Resident R229's Medication Administration Record, and Treatment	F 0694		

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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
F 0694 SS=D	Continued from page 113 Administration Record failed to include the physician order for transparent dressing changes. Observation on 2/10/25, at 12:15 p.m. Resident R229 was in the dining room working a puzzle. The left arm IV catheter site appeared soiled with dried blood underneath the dressing. The dressing failed to include a date it was last changed. Interview on 2/10/25, at 12:20 p.m. Unit Director RN Employee E19 confirmed the dressing appeared soiled with dried blood underneath, and that the dressing failed to include a date it was last changed, and a care plan was not present. Interview with the Director of Nursing on 2/14/25, at 12:30 p.m. confirmed that the facility failed to ensure that physician's orders were followed for the care of an IV Midline Catheter (a type of long-term intravenous catheter) for one of three residents reviewed (Resident R229).	F 0694		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395015	A. BLDG: __00_____ B. WING: _____	02/14/2025

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F 0694 SS=D	Continued from page 114 28 Pa. Code 211.11(a) Resident care plan. 28 Pa. Code 211.12(d)(1)(5) Nursing Services.	F 0694		
F 0695 SS=E		F 0695		

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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F 0695 SS=E	Continued from page 115 483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by:	F 0695	1. Oxygen concentrator for R42 was replaced, tubing and humidification bottle were changed. Humidification bottle for R235 was changed. Physician orders for oxygen were obtained for R811, oxygen tubing and humidification bottle were changed. 2. Director of nursing or designee will do a house audit of residents requiring oxygen to ensure orders are present for weekly changes of oxygen delivery equipment. 3. Director of nursing or designee will educate licensed nursing staff on following physician orders for changing oxygen delivery equipment and dating oxygen tubing and bottles when put in use. 4. Director of nursing or designee will audit 5 residents requiring oxygen weekly for 2 weeks, then 3 residents weekly for 2 weeks, then 3 residents monthly for 2 months to ensure that orders for changing oxygen delivery equipment are present and tubing and humidification bottles are dated.	Completion Date: **03/10/2025** Status: **APPROVED** Date: **02/28/2025**

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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F 0695 SS=E	Continued from page 116 Based on observation, clinical record review and interview, the facility failed to provide specialized care needs for the provision of respiratory care in accordance with professional standards of practice for three of six residents (Residents R42, R235 and R811). Findings include: Review of facility policy "Oxygen Administration" dated 10/1/24, indicated to change pre-filled humidification systems and tubing at least weekly. Review of the admission record indicated Resident R42 was admitted to the facility on 11/11/24. Review of Resident R42's Minimum Data Set (MDS - a periodic review of care needs) dated 11/16/24, indicated the diagnoses of high blood pressure, 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	F 0695		

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F 0695 SS=E	Continued from page 117 blood sugar and using it for energy). Review of Resident R42's physician orders dated 11/11/24, indicated change oxygen tubing, humidification bottle, and cleanse oxygen filter (replace if soiled or missing) weekly. Review of Resident R42's care plan dated 12/5/24, indicated provide oxygen therapy. Observation on 2/12/25, at 10:45 a.m. Resident R42 was in the dining room connected to an oxygen concentrator (medical device that provides 95 percent pure oxygen) running at 3 lpm (liters per minute). The tubing or humidifier contained a date last changed. The filter sponge on the back of the concentrator was missing and there was visible thick fuzz like gray debris in the filter's chamber dividers. Interview and tour on 2/12/25, at 10:45 a.m. with Unit Manager Registered Nurse (RN) Employee E6 confirmed Resident R42's tubing or humidifier contained a date last changed. The filter sponge on	F 0695		

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F 0695 SS=E	Continued from page 118 the back of the concentrator was missing and there was visible thick fuzz like gray debris in the filter's chamber dividers. Review of the admission record indicated Resident R235 was admitted to the facility on 10/20/19. Review of Resident R235's MDS dated 1/31/25, indicated the diagnoses of chronic obstructive pulmonary disease (COPD- a group of diseases that block airflow and make it hard to breathe), diabetes (a long-term condition in which the body has trouble controlling blood sugar and using it for energy) and toxic liver disease. Review of Resident R235's physician orders dated 3/5/24, indicated change oxygen tubing, humidification bottle, and cleanse oxygen filter (replace if soiled or missing) every Tuesday. Interview and tour on 2/10/25, at 10:45 a.m. with Unit Manager Registered Nurse (RN) Employee E29 confirmed Resident R235's humidification	F 0695		

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F 0695 SS=E	Continued from page 119 bottle was empty. Review of the clinical record revealed that Resident R811 was admitted to the facility on 1/29/25. Review of Resident 811's MDS dated 2/5/25, indicated diagnoses of alcoholic cardiomyopathy (the heart is unable to pump blood efficiently, leading to heart failure from prolonged alcohol consumption), sarcoidosis of lung (autoimmune disease where the immune system starts attacking the body, forming small inflammatory lumps called granulomas), and depression. Review of Resident R811's physician orders failed to include oxygen administration or maintenance of equipment. Review of Resident R811's baseline care plan dated 1/30/25, indicated oxygen as ordered. Observation on 2/10/25, at 9:24 a.m. Resident R811 was in bed with a nasal cannula (thin tubes	F 0695		

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F 0695 SS=E	Continued from page 120 that deliver oxygen through the nostrils) in his nose. Tubing was not dated. The tubing was connected to an empty humidification bottle, that was not dated on the wall. Interview and tour on 2/10/25, at 9:30 a.m. with Unit Manager Registered Nurse (RN) Employee E6 confirmed Resident R811's oxygen equipment was not dated, and the humidification bottle was empty. Interview on 2/14/25, at 3:00 p.m. the Director of Nursing confirmed the facility failed to provide specialized care needs for the provision of respiratory care in accordance with professional standards of practice for three of six residents (Residents R42, R235, and R811). 28 Pa. Code: 201.29(j) Resident rights. 28 Pa. Code 211.5(f) Clinical Records 28 Pa. Code: 211.10(c)(d) Resident care policies. 28 Pa. Code: 211.12(d)(1)(2)(3)(5) Nursing services.	F 0695		

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F 0695 SS=E	Continued from page 121	F 0695		
F 0698 SS=D	483.25(l) Dialysis §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by:	F 0698	1. The facility can not retroactively correct the missed dialysis communication as it relates to R113 and R213. Review of physician orders was completed to ensure physician orders are present for access site monitoring. 2. A house audit was done of residents receiving dialysis to ensure physician orders are present for monitoring of dialysis access site, no issues identified. 3. Director of nursing or designee will in-service licensed nursing staff on completing bottom section of dialysis communication form upon return from dialysis. 4. Director of nursing or designee will audit 5 residents weekly for 2 weeks, then 3 residents weekly for 2 weeks, then 3 residents monthly for 2 months to ensure bottom section of dialysis communication form is completed. Audit findings will be shared with QAPI committee.	Completion Date: **03/10/2025** Status: **APPROVED** Date: **02/28/2025**

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F 0698 SS=D	Continued from page 122 Based on review of facility policy and clinical record and staff interview it was determined that the facility failed to make certain consistent dialysis communication was maintained for two of five dialysis residents (Residents R113, and R213). Findings include: Review of the facility policy "Dialysis Care" dated 10/1/24, indicated all residents receiving dialysis (a treatment for advanced kidney failure that filters wastes, salts, and fluid from your blood) therapy will be monitored and documentation will be maintained in the medical record. They will be assessed before and after dialysis treatment for compliance with their individualized plan of care. Review of the admission record indicated R113 was admitted to the facility on 1/16/25. Review of Resident R113's Minimum Data Set (MDS - a periodic assessment of care needs) dated 1/22/25, indicated the diagnoses of stroke (damage	F 0698		

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F 0698 SS=D	Continued from page 123 to the brain from an interruption of blood supply), anemia (the blood doesn't have enough healthy red blood cells), End Stage Renal Disease (ESRD - kidneys cease to function on a permanent basis leading to the need for a regular course of long-term dialysis or a kidney transplant to maintain life), and hip fracture (broken bone in hip). Review of Resident R113's physician order dated 1/17/25, indicated leave for dialysis at 8:00 a.m. every Tuesday, Thursday, and Saturday. Review of Resident R113's care plan dated 1/17/25, indicated to monitor dialysis catheter for bleeding. If bleeding apply direct pressure, notify physician for further orders. Review of Resident R113's dialysis communication sheets dated 1/18/25, through 2/8/25, indicated failure to complete the communication forms upon return to facility following dialysis on ten occasions (2/8/25, 2/6/25, 2/4/25, 2/1/25, 1/30/25, 1/28/25, 1/25/25, 1/23/25, 1/21/25, and 1/18/25).	F 0698		

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F 0698 SS=D	Continued from page 124 Interview on 2/10/25, at 12:50 p.m. Unit Director RN Employee E19 confirmed Resident R113's dialysis communication forms were not completed upon return to facility following dialysis on ten occasions (2/8/25, 2/6/25, 2/4/25, 2/1/25, 1/30/25, 1/28/25, 1/25/25, 1/23/25, 1/21/25, and 1/18/25). Review of the admission record indicated Resident R 213 admitted to the facility on 6/11/24. Review of the Resident R213's MDS dated 11/2/24, indicated the diagnoses of anemia, heart failure (heart doesn't pump blood as well as it should), and diabetes (a long-term condition in which the body has trouble controlling blood sugar and using it for energy). Review of Resident R213's physician order dated 1/23/25, indicated leave for dialysis at 5:30 a.m. every Monday, Wednesday, and Friday. Review of Resident R213's care plan dated	F 0698		

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F 0698 SS=D	Continued from page 125 12/30/24, indicated to monitor dialysis catheter for bleeding. If bleeding apply direct pressure, notify physician for further orders. Review of Resident R213's dialysis communication sheets dated 1/3/25, through 2/10/25, indicated failure to complete the communication forms upon return to facility following dialysis on 17 occasions (2/10/25, 2/7/25, 2/5/25, 2/3/25, 1/31/25, 1/29/25, 1/27/25, 1/24/25, 1/22/25, 1/20/25, 1/17/25, 1/15/25, 1/13/25, 1/10/25, 1/8/25, 1/6/25, and 1/3/25). Interview on 2/10/25, at 12:50 p.m. Unit Director RN Employee E19 confirmed Resident R213's dialysis communication forms were not completed upon return to facility following dialysis on 17 occasions (2/10/25, 2/7/25, 2/5/25, 2/3/25, 1/31/25, 1/29/25, 1/27/25, 1/24/25, 1/22/25, 1/20/25, 1/17/25, 1/15/25, 1/13/25, 1/10/25, 1/8/25, 1/6/25, and 1/3/25). Interview on 2/13/25, at 2:00 p.m. the Director of	F 0698		

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F 0698 SS=D	Continued from page 126 Nursing confirmed the facility failed to make certain consistent dialysis communication was maintained for two of five dialysis residents (Residents R113, and R213). 28 Pa. Code: 201.14(a) Responsibility of licensee. 28 Pa. Code: 211.10(d) Resident care policies. 28 Pa. Code: 201.18 (b) (1) (e) (1) Management. 28 Pa. Code: 211.12 (d) (1) (2) (5) Nursing services.	F 0698		
F 0699 SS=E		F 0699		

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F 0699 SS=E	Continued from page 127 483.25(m) Trauma Informed Care §483.25(m) Trauma-informed care The facility must ensure that residents who are trauma survivors receive culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident. This REQUIREMENT is not met as evidenced by:	F 0699	1. R296 is no longer in facility. Care plans for R51, R33, R141 and R168 were updated to reflect triggers that may exacerbate PTSD symptoms. 2. A house audit will be completed to ensure all residents with a PTSD diagnosis have potential triggers identified in their plan of care. 3. Director of nursing or designee will in-service social workers on identifying triggers associated with a PTSD diagnosis so that the plan of care includes interventions to mitigate stressors. 4. Director of nursing or designee will audit 2 residents with a PTSD diagnosis weekly for 4 weeks to ensure care plan includes identified triggers and interventions to mitigate stressors. Audit findings will be shared with QAPI committee.	Completion Date: **03/10/2025** Status: **APPROVED** Date: **02/28/2025**

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F 0699 SS=E	Continued from page 128 Based on review of facility policy, resident record review, and staff interviews, it was determined that the facility failed to provide a trauma survivor with trauma informed care to eliminate or mitigate triggers that may cause re-traumatization of the resident for five of six residents (Residents R33, R51, R141, R168, and R296). Findings include: Review of facility policy "Trauma Informed Care" dated 10/1/24, indicated the facility will develop individualized care plans that address past trauma in collaboration with the resident and family, as appropriate and identify and decrease exposure to triggers that may re-traumatize the resident. Review of Resident R33's record indicated the resident was admitted on 3/29/23. Diagnoses included major depressive disorder, opioid dependance and Post Traumatic Stress Disorder (PTSD - a disorder in which a person has difficulty recovering after experiencing or witnessing a	F 0699		

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F 0699 SS=E	Continued from page 129 terrifying event and may have triggers that can bring back memories of trauma accompanied by intense emotional and physical reactions). Review of Resident R33's assessments did not include a Trauma Informed Care Evaluation (a data collection tool that gathers information on traumatic events and aids in identifying and addressing the resident's needs). Review of Resident R33's care plan initiated 8/14/24, did not include a plan of care developed with goals or interventions for post-traumatic stress disorder. Review of Resident R51's record indicated the resident was admitted on 7/20/23. Diagnoses included congestive heart failure, chronic kidney disease and post-traumatic stress disorder. Review of Resident R51's assessments did not include a Trauma Informed Care Evaluation.	F 0699		

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F 0699 SS=E	Continued from page 130 Review of Resident R51's care plan initiated 9/5/23, did not include a plan of care developed with goals or interventions for post-traumatic stress disorder. Review of Resident R141's admission record indicated he was admitted 8/22/14. Review of Resident R141's MDS assessment (MDS: Minimum Data Set assessment-a periodic assessment of resident care needs) dated 11/18/24, indicated he had diagnoses that include Bipolar disorder (a disorder associated with episodes of mood swings ranging from depressive lows to manic highs), PTSD, diabetes (metabolic disorder impacting organ function related to glucose levels in the human body) and dementia (a condition characterized by memory loss and progressive or persistent loss of intellectual functioning). Review of Resident R141's Certified Registered Nurse Practitioner note dated 12/23/24, indicated that he PTSD and dementia since admission.	F 0699		

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F 0699 SS=E	Continued from page 131 Review of Resident R141's care plans dated 12/3/24, did not include PTSD psychological triggers for trauma informed care. Review of Resident R168's admission record indicated he was originally admitted on 8/18/18. Review of Resident R168's MDS assessment dated 1/8/25, indicated he had diagnoses that included paraplegia (a form of paralysis impacting the lower extremities of the body)., chronic pain disorder, and PTSD. Review of Resident R168's psychiatric evaluation note dated 1/21/25, indicated he experienced no PTSD symptoms as per staff. Review of Resident R168's care plans dated 11/8/24, did not include PTSD psychological triggers for trauma informed care. During an interview on 2/12/25, at 12:35 p.m. Registered Nurse (RN) Supervisor Employee E8	F 0699		

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F 0699 SS=E	Continued from page 132 confirmed that the facility failed to develop and implement individualized person-centered plans to render trauma informed care to residents with a diagnosis of PTSD for Residents R141 and R168 as required. Review of the clinical record indicated Resident R296 was admitted to the facility on 5/30/23. Review of Resident R296's clinical record revealed diagnoses of high blood pressure, malnutrition (lack of sufficient nutrients in the body), and PTSD. Review of Resident R296's care plan on 2/10/25, did not include a plan of care developed with goals and interventions related to post-traumatic stress disorder. During an interview on 2/13/25, at 1:13 p.m. Director of Social Services Employee E9 confirmed that the facility failed to assess Residents R33 and R51, failed to develop a care plan related to post-traumatic stress disorder for Resident R33, R51 and R296. and failed to provide a trauma	F 0699		

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F 0699 SS=E	Continued from page 133 survivor with trauma informed care to eliminate or mitigate triggers that may cause re-traumatization of the resident for five of six residents as required. 28 Pa. Code: 201.14(a) Responsibility of licensee. 28 Pa. Code: 201.18(b)(1) Management.	F 0699		
F 0712 SS=E		F 0712		

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F 0712 SS=E	Continued from page 134 483.30(c)(1)-(4) Physician Visits-Frequency/Timeliness/Alt NPP §483.30(c) Frequency of physician visits §483.30(c)(1) The residents must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 thereafter. §483.30(c)(2) A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required. §483.30(c)(3) Except as provided in paragraphs (c)(4) and (f) of this section, all required physician visits must be made by the physician personally. §483.30(c)(4) At the option of the physician, required visits in SNFs, after the initial visit, may alternate between personal visits by the physician and visits by a physician assistant, nurse practitioner or clinical nurse specialist in accordance with paragraph (e) of this section. This REQUIREMENT is not met as evidenced by:	F 0712	1. R116, R229 and R422 were seen by a physician and had history and physical completed. 2. An audit was done of admissions for the previous 30 days to ensure residents were seen by a physician for a full history and physical, no issues identified. Verbiage for NP visits needed prior to initial physician visit has been changed to "medical stabilization visit" 3. Director of nursing will meet with medical director to review regulatory requirements related to physician visits. 4. Director of nursing or designee will audit 2 new admissions weekly for 4 weeks to ensure initial history and physical is completed by a physician. Audit findings will be shared with QAPI committee.	Completion Date: **03/10/2025** Status: **APPROVED** Date: **02/28/2025**

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F 0712 SS=E	Continued from page 135 Based on review of clinical records, as well as staff interviews, it was determined that the facility failed to ensure a physician completed the initial visit for three of three residents (Resident R116, R229, and R422). Findings include: Review of Resident R116's clinical record indicated admission to the facility on 6/6/24. Review of Resident R116's Minimum Data Set (MDS - a periodic assessment of care needs) dated 6/13/24, indicated diagnoses of dementia (occurs when the supply of blood to the brain is reduced or blocked completely, which prevents brain tissue from getting oxygen and nutrients.) hypertension (high blood pressure) and depression. Review of Resident R116's clinical record revealed a new patient visit was completed by Certified Registered Nurse Practitioner, Employee E35 on 6/7/24. The facility failed to ensure the resident's	F 0712		

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F 0712 SS=E	Continued from page 136 initial visit was conducted by a physician. Review of Resident R229's clinical record indicated admission to the facility on 12/5/24. Review of Resident R229's MDS dated 12/12/24, indicated diagnoses of osteomyelitis (infection in the bone caused by bacteria or fungi), spina bifida occulta (a condition where a gap forms between the small bones (vertebrae) of your backbone (spine), and lymphedema (a chronic condition characterized by abnormal and persistent swelling). Review of Resident R229's clinical record revealed a new patient visit was completed by Certified Registered Nurse Practitioner, Employee E36 on 12/6/24. The facility failed to ensure the resident's initial visit was conducted by a physician. Review of Resident R422's clinical record indicated admission to the facility on 12/10/24. Review of Resident R422's MDS dated 12/17/24,	F 0712		

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F 0712 SS=E	Continued from page 137 indicated diagnoses of traumatic brain injury, anxiety, and hypertension. Review of Resident R422's clinical record revealed a new patient visit was completed by Certified Registered Nurse Practitioner, Employee E37 on 12/11/24. The facility failed to ensure the resident's initial visit was conducted by a physician. During an interview on 2/14/25, at 10:16 a.m. the Director of Nursing confirmed the facility failed to ensure a physician completed the initial visit for three of three residents (Resident R116, R229, and R422). 28 Pa. Code 211.2(a) Physician Services.	F 0712		
F 0726 SS=J		F 0726		

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F 0726 SS=J	Continued from page 138 483.35(a)(3)(4)(c) Competent Nursing Staff §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71. §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by:	F 0726	1. Care plan and physician orders for care of life vest for R811 were updated. 2. An audit was done of residents requiring life vest in facility, there were none. 3. Admissions director was in-serviced by director of nursing on notifying nursing administration of any admissions to facility requiring life vest prior to admission. Director of nursing will in-service nursing leadership on identifying and reporting educational needs for equipment or procedures to nursing administration. Nursing staff were educated on care of the life vest, including how the life vest works, what audible alerts mean, cleaning of the vest and removing for hygiene. Facility has contracted with Core Tactics for onsite in-service training to occur on 3/11/2025 and 3/12/2025 for use and care of resident with life vest. 4. Director of nursing or designee will audit new admissions for 30 days to ensure residents with special equipment needs are communicated	Completion Date: **03/13/2025** Status: **APPROVED** Date: **03/03/2025**

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F 0726 SS=J	Continued from page 139	F 0726	to the nursing department and needed education is provided. Audit results will be shared with QAPI.	

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F 0726 SS=J	Continued from page 140 Based on manufacturer's guidelines, facility policy, clinical record review, and staff interview it was determined that the facility failed to ensure that nursing staff have the specific competencies and skill sets necessary to provide care for a resident with a Life Vest (a wearable defibrillator designed to protect residents from sudden cardiac death), and placed one resident (Resident R811) in immediate jeopardy in which health and safety were impacted. Findings include: Review of the manufacturer's guidelines "Life Vest Pocket Card" indicated the following: -The Life Vest is a wearable cardiac defibrillator (a device that applies an electric charge to the heart to restore a normal heart beat). -The "Respond" message means: before delivering a treatment shock, Life Vest test to see if a patient is conscious (aware of their environment) by providing the patient an opportunity to press the response button to prevent a treatment shock. It is important that only the patient press the response button.	F 0726		

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F 0726 SS=J	Continued from page 141 -Life Vest therapy pads release a blue gel prior to a treatment shock to both improve shock conduction (the process by which heat or electricity is directly transmitted through a substance) and mitigate burning. The gel should remain on the patient as long as the patient is wearing the Life Vest in case additional treatment shocks are required. -Life Vest treats a ventricular (ventricles - the two lower chambers of the heart) arrhythmia (improper beating of the heart, irregular, too fast, or too slow). The time to treatment will be between 25 and 60 seconds depending on the type and rate of the arrhythmia and whether the patient presses the response buttons. -Nobody should touch the patient while a treatment shock is delivered. The device will warn bystanders with both a siren alert and a voice command stating "Bystanders, do not interfere." before a shock is delivered. -Vibrations, along with the siren alerts and voice prompts are part of the device's consciousness test, which requires the patient to press the response button to avoid a shock. It is important that only the	F 0726		

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F 0726 SS=J	Continued from page 142 patient press the response button. -When possible the patient should bring the Life Vest charger, hotspot and extra battery to the hospital which allows the patient to download any stored data from the monitor and change the battery as required. Review of the facility policy "Life Vest" dated 10/1/24, indicated the facility is to establish procedures for the safe use of wearable defibrillators. The residents' wearable defibrillator will be in accordance with physician orders, and the medical record will include the following: -Name and contact information of the manufacturer. -Name and contact information of the ordering cardiologist or specialist. -Product pamphlet or web address to access product pamphlet for operating instructions and/or trouble shooting information. Staff responsible for the care of the resident with orders for a wearable defibrillator shall receive education on the use of the device, which is includes but is not limited to:	F 0726		

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F 0726 SS=J	Continued from page 143 -Purpose of the device and how it works. -Application and care of the garment. -Application of and operating instructions of the monitor. -How to respond to alarms. -When to notify attending or ordering physician. -When to notify manufacturer for replacement. Review of the clinical record revealed that Resident R811 was admitted to the facility on 1/29/25. Review of Resident R811's MDS (Minimum Data Set, periodic assessment of resident care needs) dated 2/5/25, indicated diagnoses of alcoholic cardiomyopathy (the heart is unable to pump blood efficiently, leading to heart failure from prolonged alcohol consumption), sarcoidosis of lung (autoimmune disease where the immune system starts attacking the body, forming small inflammatory lumps called granulomas), and depression. Review of Resident R811's Nursing admission evaluation dated 1/29/25, indicated Section H	F 0726		

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F 0726 SS=J	Continued from page 144 Cardiac/circulation - irregular rate. Section L Skin indicated chest - Life Vest. Review of Resident R811's physician order dated 1/30/25, indicated check Life Vest placement and battery daily. Change Battery daily for Life Vest one time a day. Review of Resident R811's care plan on 2/10/25, failed to include a problem, goal, or interventions for care and management of Life Vest. Observation of Resident R811 on 2/10/25, at 9:29 a.m. in bed under blanket with a device stored inside a black bag attached to his person on top of the blanket. Interview with Resident R811 on 2/10/25, at 9:30 a.m. indicated "Yes, I have a Life Vest, and no, the staff don't know how to use it. I change my own battery every night around 10:00 p.m. The hospital only sent me with one garment".	F 0726		

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F 0726 SS=J	Continued from page 145 Interview on 2/11/25, at 9:01 a.m. Nurse Aide (NA) Employee E1 indicated "I don't know what a Life Vest is. I've never been trained at this facility". Interview on 2/11/25, at 9:08 a.m. NA Employee E2 indicated "A Life Vest is something they get at the hospital, it monitors their heart. I've never been trained by this facility, but we have a resident with Life Vest in room 217-1 Resident R811". Survey Agency (SA) asked "Is he allowed to take that off for showers?" NA Employee E2 indicated "I don't think so, because I don't think he's allowed to ever take it off". Interview on 2/11/25, at 9:20 a.m. Registered Nurse (RN) Wound Care Employee E3 indicated "I've never had Life Vest training at this facility". Interview on 2/11/25, at 9:25 a.m. RN Employee E4 indicated "A Life Vest is like a defibrillator, you can take off in the shower, I'm not sure for how long. I have not been trained at this facility on Life Vest".	F 0726		

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F 0726 SS=J	Continued from page 146 Interview on 2/11/25, at 9:30 a.m. Unit Director RN Employee E5 indicated she was in training and that they had Resident 811 with a Life Vest at the current time. "I have not received training at this facility on Life Vest". Interview on 2/11/25, at 9:31 a.m. Unit Director RN Employee E6 indicated "I've never been trained on Life Vest at this facility". On 2/11/25, at 10:35 a.m., the Nursing Home Administrator (NHA) and Director of Nursing (DON) were made aware that Immediate Jeopardy (IJ) existed, NHA was provided the IJ Template, that placed one resident (Resident R811) in immediate jeopardy in which health and safety were impacted, and a corrective action plan was requested. On 2/11/25, at 3:07 p.m., an acceptable Corrective Action Plan was received which included the following interventions:	F 0726		

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F 0726 SS=J	Continued from page 147 Immediate Action: -Facility will implement immediate education for nursing staff for care and operation of the Life Vest, on 2/11/25, to include what alerts mean, first responder instructions, emergency patient management, showering and laundering of vest. All additional staff will be in-serviced on care and operation of the Life Vest prior to the next shift worked. Any staff not scheduled prior to 2/12/25 will be contacted via telephone and educated prior to the next scheduled shift. Residents: -Resident R811's care plan will be revised to include use of the Life Vest on 2/11/25. Physician orders for R811 will be reviewed to ensure orders for care and operation of the Life Vest are present and being followed on 2/11/25. System Correction: -The NHA and DON will review the policy and procedure for use of the Life Vest to be revised as	F 0726		

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F 0726 SS=J	Continued from page 148 necessary on 2/11/25. Policy for ensuring equipment needs on new admissions will be reviewed and revised to include communication of equipment needs by admissions staff to nursing staff prior to admission. Admissions director will be re-inserviced on communicating equipment needs to nursing department. Education needs regarding use of equipment will be assessed and provided prior to use. Monitoring: -The NHA will audit all new admissions for 30 days to ensure all equipment needs for new admissions are being met and staff are educated on equipment prior to use. Education, policy revision, and ongoing audits will be shared with Quality Assurance and Performance Improvement (QAPI) committee. During an interview on 2/12/25, at 11:00 a.m. NA Employee E2 indicated, "Yes, I was trained on the Life Vest. They said he could take a shower, and I went in with him when he removed the vest. I'm	F 0726		

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F 0726 SS=J	Continued from page 149 glad I know now". During an interview on 2/12/25, at 11:05 a.m. NA Employee E1 indicated "I was trained on the Life Vest. It's pretty amazing what that thing can do. I feel better about it now." During an interview on 2/12/25, at 11:15 a.m. RN Employee E4 indicated " I was trained on the Life Vest. Now I know how long it can be off for." During interviews on 2/12/25 - 2/13/25, a total of 64 in person interviews of clinical staff was conducted and verified Life Vest training had occurred, and they had understanding of the education. -Verified the DON trained 91.1% of nursing staff. -Verified Resident R811's care plan was revised to include use of the Life Vest. Physician orders were reviewed and include the operation of the Life Vest on 2/12/25, at 9:10 a.m. -Verified the NHA and DON reviewed and revised the policy for Life Vest and policy for ensuring	F 0726		

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F 0726 SS=J	Continued from page 150 equipment needs by admissions staff to nursing staff prior to admission. Admission Director was re-educated on 2/12/25. -Verified the NHA will audit all new admissions for 30 days to ensure all equipment needs for new admissions are being met and staff are educated on equipment prior to use. Education, policy revision, and ongoing audits will be shared with Quality Assurance and Performance Improvement (QAPI) committee. -Verified the DON completed an audit on 2/12/25, at 11:08 am of all new admissions as of 2/11/25. Next meeting is 2/27/25. The Immediate Jeopardy was lifted on 2/13/25, at 11:51 a.m. when the action plan was verified. During an interview on 2/11/25, at 10:35 a.m. the NHA and DON confirmed that the facility failed to ensure that nursing staff have the specific competencies, and skill sets necessary to provide care for a resident with a Life Vest which created a situation that placed one resident (Resident R811) in	F 0726		

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F 0726 SS=J	Continued from page 151 immediate jeopardy in which health and safety were impacted. 28 Pa Code 201.14(a) Responsibility of licensee. 28 Pa Code 201.18(a)(b)(1)(e)(1) Management. 28 Pa Code 201.29(a)Resident rights. 28 Pa Code 211.5(f) Clinical records 28 Pa. Code: 211.10 (c)(d) Resident care policies 28 Pa Code 211.12(c)(d)(1)(2)(5) Nursing services	F 0726		
F 0761 SS=D		F 0761		

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F 0761 SS=D	Continued from page 152 483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by:	F 0761	1. Treatment creams were removed from 3 main north hall medication cart. Medication in cup was removed from top of Grove 1 back hall medication cart. Expired supplies were discarded from 5 main medication room. Items being stored under sink on 5 main were removed. Expired TB solution was removed from 2 main medication fridge and discarded. Unlabeled insulin pen in grove 2 medication fridge was discarded. 2. A house audit was done of medication carts and med rooms on all units to ensure no items were stored under sink, carts and med rooms were free of expired supplies and medication carts did not contain treatment creams. Medication room refrigerators were checked to ensure all unopened insulin pens were labeled and bagged. 3. Director of nursing or designee will educate licensed nursing staff on not storing items under sinks, proper storage of treatment supplies and medications, and discarding expired supplies.	Completion Date: **03/10/2025** Status: **APPROVED** Date: **02/28/2025**

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F 0761 SS=D	Continued from page 153	F 0761	4. Director of nursing or designee will audit 4 units (4 medication rooms and 8 medication carts) weekly for 2 weeks, then 2 units (2 medication rooms and 4 medication carts) weekly for 2 weeks, then 2 units (2 medication rooms and 4 medication carts) monthly for 2 months to ensure proper storage of drugs and biologicals and not items being stored under the sinks. Audit findings will be shared with QAPI committee.	

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F 0761 SS=D	Continued from page 154 Based on review of facility policy, observations and staff interview it was determined that the facility failed to store medications and biologicals as required for two of 12 medication carts (1 Grove Back Medication Cart and 3 Main Medication Cart) and three of six medication rooms (2 Grove Medication Room, 2 Main Medication Room, and 5 Main Medication Room). Findings include: Review of facility policy "Storage of Medications" dated 10/1/24, indicated drug containers having soiled, illegible, worn, makeshift, incomplete, damaged, or missing labels are relabeled before storing. Compartments containing medications are locked when not in use. Trays or carts used to transport such items are not left unattended. During an observation on 2/11/25, at 12:40 p.m. of the Third Main North Medication cart, three treatments were observed inside the medication cart that included:	F 0761		

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F 0761 SS=D	Continued from page 155 - One tube of Bengay (cream used for pain) - Tender Calm skin protectant (skin cream) - Zinc Oxide Ointment (used to protect skin) During an interview on 2/11/25, at 12:45 p.m. Licensed Practical Nurse (LPN) Employee E16 confirmed that treatments were in the medication cart and should be kept in the treatment cart. During an observation on 2/12/25, at 9:11 a.m. of the 1 Grove Back Medication Cart a medication cup with one white pill was observed sitting on top of the medication cart and left unattended. During an interview on 2/12/25, at 9:20 a.m. Registered Nurse (RN) Employee E10 confirmed that the medication was left unattended on top of the 1 Grove Back Medication Cart and that the facility failed to store medications and biologicals as required. During an observation on 2/11/25, 10:50 a.m. of	F 0761		

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F 0761 SS=D	Continued from page 156 Fifth Main Medication Room revealed expired supplies included: - one nasogastric feeding tube (tube inserted through your nose to your stomach) dated 4/30/24. - one foley catheter (tube that drains urine from your bladder) dated 1/29/24. During an observation on 2/11/25, at 11:00 a.m. of Fifth Main Medication Room revealed items being stored underneath the sink that included: - filled sharps (needles, glass) container -bleach wipes -drug buster (used to dispose medication) -gallon of bleach -gallon of vinegar During an interview on 2/11/25, at 11:06 a.m. LPN Employee confirmed the above findings in Fifth Main Medication Room being stored underneath the sink.	F 0761		

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F 0761 SS=D	Continued from page 157 During an observation on 2/11/25, at 1:00 p.m. of Second Main Medication Room refrigerator revealed an outdated vial of Tuberculin (TB-a medication used to test for respiratory disease), dated 9/30/24. During an interview on 2/11/25, at 1:07 p.m. RN Employee E17 confirmed the outdated vial of TB stored in the refrigerator. Observation on 2/12/25, at 9:22 a.m. of 2 Grove's medication room refrigerator indicated an insulin glargine pen (prefilled pen to inject long-acting insulin under the skin), that failed to have a label with resident's name and was not contained in a bag. Interview on 2/12/25, at 9:24 a.m. Unit Director RN Employee E6 confirmed the insulin glargine pen failed to have a label with resident's name and was not contained in a bag as required. Interview on 2/14/25, at 3:00 p.m. the Director of Nursing confirmed that the facility failed to store	F 0761		

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F 0761 SS=D	Continued from page 158 medications and biologicals as required for two of 12 medication carts (1 Grove Back Medication Cart and 3 Main Medication Cart) and three of six medication rooms (2 Grove Medication Room, 2 Main Medication Room, and 5 Main Medication Room). 28 Pa. Code: 211.12(d)(1)(2)(3)(5) Nursing services.	F 0761		
F 0791 SS=D		F 0791		

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F 0791 SS=D	Continued from page 159 483.55(b)(1)-(5) Routine/Emergency Dental Srvcs in NFs §483.55 Dental Services The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(b) Nursing Facilities. The facility- §483.55(b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(f) of this part, the following dental services to meet the needs of each resident: (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services; §483.55(b)(2) Must, if necessary or if requested, assist the resident- (i) In making appointments; and (ii) By arranging for transportation to and from the dental services locations; §483.55(b)(3) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay;	F 0791	1. R250 was placed on the schedule to see the dentist. Appointment occurred 2/13/2025. 2. Director of nursing met with physician services to staff to ensure they know how to pull consult orders from the electronic medical record. 3. Director of nursing or designee will in-service physician services staff on scheduling dental consults in a timely manner and to notify administration of any delays. 4. Director of nursing or designee will audit 5 resident weekly for 2 weeks, then 3 residents weekly for 2 weeks, then 3 residents weekly for 2 months to ensure orders for dental consults are being scheduled in a timely manner. Audit findings will be shared with QAPI committee.	Completion Date: **03/10/2025** Status: **APPROVED** Date: **02/28/2025**

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F 0791 SS=D	Continued from page 160 §483.55(b)(4) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; and §483.55(b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan. This REQUIREMENT is not met as evidenced by:	F 0791		

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F 0791 SS=D	Continued from page 161 Based on clinical record review, facility documents and staff interviews, it was determined that the facility failed to provide dental services to meet the needs of residents for one of three residents reviewed (Residents R250). Findings include: Review of the facility "Dental Services" policy dated 10/1/24, indicated the facility will assist residents in obtaining routine dental care. This requirement makes the facility directly responsible for the dental care needs of the residents. Review of the clinical record revealed that Resident R250 was admitted to the facility on 2/24/20, and readmitted 8/21/24. Review of Resident R250's care plan dated 4/11/24, indicated the resident is at risk for altered dentition and/or mucus membrane related to obvious or likely cavity or broken natural teeth. It was indicated to obtain a dental consult as necessary.	F 0791		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395015	A. BLDG: __00_____ B. WING: _____	02/14/2025

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F 0791 SS=D	Continued from page 162 Review of Resident R250's physician order dated 10/7/24, indicated to consult the dentist for routine evaluation. Review of Resident R250's MDS (Minimum Data Set, periodic assessment of resident care needs) dated 1/31/25, indicated diagnoses of high blood pressure, depression, and dementia (loss of cognitive functioning, thinking, remembering, and reasoning to such an extent that it interferes with a person's daily life and activities). During an interview on 2/12/25, at 11:36 a.m. Transportation Aide, Employee E34 confirmed Resident R250 was not seen by the dentist as ordered. During an interview on 2/12/25, at 11:51 a.m. the Director of Nursing confirmed the facility failed to provide dental services to meet the needs of residents for one of three residents (Residents R250).	F 0791		

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F 0791 SS=D	Continued from page 163 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services 28 Pa. Code 211.15. Dental services	F 0791		
F 0812 SS=F	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	F 0812	1. Ice machines were cleaned. The fan(s) were cleaned and removed. 2. The kitchen was audited to ensure sanitary conditions were maintained. 3. The director of food services was re in-services by the NHA to ensure the kitchen maintains sanitary conditions. 4. The director of food services or designee will audit the ice machines monthly to ensure ice machines and fans are clean of debris. Audit findings will be reviewed with QAPI committee	Completion Date: **03/10/2025** Status: **APPROVED** Date: **03/03/2025**

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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F 0812 SS=F	Continued from page 164 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		

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F 0812 SS=F	Continued from page 165 Based on observations and staff interview, it was determined that the facility failed to properly maintain sanitary conditions in the main kitchen which created the potential for cross contamination. Findings include: During an observation of the main designated kitchen on 2/10/25, at 9:05 a.m. the following was observed: -brown debris in ice machine (two) -brown, fuzzy debris on wall fans (three) During an interview on 2/10/25, at 9:30 a.m. Dietary Manager Employee E24 confirmed the debris in ice machines. Employee E24 could not confirm the last time they were cleaned. During an interview on 2/10/25, at 9:45 a.m., Dietary Manager Employee E24 confirmed that the facility failed to maintain sanitary conditions in the main kitchen which created the potential for food borne illness.	F 0812		

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F 0812 SS=F	Continued from page 166 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.	F 0812		
F 0835 SS=F	483.70 Administration §483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by:	F 0835	1. Assessments and care plans were reassessed by nursing department for all residents to ensure accurate identification of elopement risk. All employees were re in serviced by nursing administration on proper assessment and care-planning to identify elopement like behaviors. 2. The NHA and Director of Nurses were re in serviced by Core tactics consulting firm representative on elopement risk and policy and procedure and their respective job descriptions to ensure residents were free from the risk of elopement. 3. The NHA and Director of Nursing audit monthly for three months following initial daily audit x 30 days to ensure residents at risk for elopement have an assessment and care plan for elopement risk.	Completion Date: **03/10/2025** Status: **APPROVED** Date: **03/03/2025**

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F 0835 SS=F	Continued from page 167 Based on review of job descriptions, clinical records and staff interviews, it was determined that the Nursing Home Administrator (NHA) and the Director of Nursing (DON) failed to effectively manage the facility to prevent the elopement of a resident (Resident R456), which created an immediate jeopardy situation for all 461 of 461 residents. Findings include: The job description for the Nursing Home Administrator dated 10/10/23, specified the primary purpose of the job is to manage the facility in accordance with current applicable, federal, state, and local standards, guidelines, and regulations the govern long-term care facilities. It is the NHA job to follow all facility policies and to ensure the highest degree of quality care is provided to the residents at all times. The job description for the Director of Nursing dated 3/22/21, specified it is the responsibility of the	F 0835		

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F 0835 SS=F	Continued from page 168 DON to organize, develop, and direct the overall operations of the Nursing Service Department in accordance with current federal, state and local standards, guidelines and regulations that govern the facility. Based on findings identified in this report, the facility failed to prevent the elopement of a resident who resided on a locked unit (Resident 456), which placed the residents in Immediate Jeopardy. The NHA and the DON failed to fulfill their essential job duties to ensure the federal and state guidelines and regulations were followed. During an interview on 2/11/25, at 10:13 a.m. the NHA and DON were notified that they failed to effectively manage the facility to prevent the elopement of a resident, which created an immediate jeopardy situation for all residents. 28 Pa. Code 201.14(a) Responsibility of licensee. 28 Pa. Code 201.18(b)(1)(3)(e)(1) Management. 28 Pa. Code 207.2 (a) Administrator's	F 0835		

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F 0835 SS=F	Continued from page 169 responsibility. 28 Pa. Code 211.12(d)(1)(2)(3)(5) Nursing services.	F 0835		
F 0838 SS=D	483.71(a)(1)(3)(b)(1)(c)(1)-(5) Facility Assessment §483.71 Facility assessment. The facility must conduct and document a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations (including nights and weekends) and emergencies. The facility must review and update that assessment, as necessary, and at least annually. The facility must also review and update this assessment whenever there is, or the facility plans for, any change that would require a substantial modification to any part of this assessment. §483.71(a) The facility assessment must address or include the following: §483.71(a)(1) The facility's resident population, including, but not limited to: (i) Both the number of residents and the facility's resident capacity; (ii) The care required by the resident population, using evidence-based, data-driven "methods" that considering	F 0838	1. The facility assessment was reviewed by the administrative team. The words "aka life vest" were added to section 2.1 subsection Heart/circulatory system where "Presence of cardiac pacemaker / heart monitoring systems" was already listed. 2. The NHA will continue to review the facility assessment at least quarterly to ensure descriptors of facility are accurate to the care being provided in the facility.	Completion Date: **03/10/2025** Status: **APPROVED** Date: **02/28/2025**

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F 0838 SS=D	Continued from page 170 the types of diseases, conditions, physical and behavioral health needs, cognitive disabilities, overall acuity, and other pertinent facts that are present within that population, consistent with and informed by individual resident assessments as required under § 483.20; (iii) The staff competencies and skill sets that are necessary to provide the level and types of care needed for the resident population; (iv)The physical environment, equipment, services, and other physical plant considerations that are necessary to care for this population; and (v) Any ethnic, cultural, or religious factors that may potentially affect the care provided by the facility, including, but not limited to, activities and food and nutrition services. §483.71(a)(2) The facility's resources, including but not limited to the following: (i) All buildings and/or other physical structures and vehicles; (ii) Equipment (medical and non- medical); (iii) Services provided, such as physical therapy, pharmacy, behavioral health, and specific rehabilitation therapies; (iv) All personnel, including managers, nursing and other direct care staff (both employees and those who provide services under contract), and volunteers, as well as their education and/or training and any competencies related to resident care; (v) Contracts, memorandums of understanding, or other agreements with third parties to provide services or	F 0838		

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F 0838 SS=D	Continued from page 171 equipment to the facility during both normal operations and emergencies; and (vi) Health information technology resources, such as systems for electronically managing patient records and electronically sharing information with other organizations. §483.71(a)(3) A facility-based and community-based risk assessment, utilizing an all-hazards approach as required in §483.73(a)(1). § 483.71(b) In conducting the facility assessment, the facility must ensure: § 483.71(b)(1) Active involvement of the following participants in the process: (i) Nursing home leadership and management, including but not limited to, a member of the governing body, the medical director, an administrator, and the director of nursing; and (ii) Direct care staff, including but not limited to, RNs, LPNs/LVNs, NAs, and representatives of the direct care staff, if applicable. (iii) The facility must also solicit and consider input received from residents, resident representatives, and family members. §483.71(c) The facility must use this facility assessment to: §483.71(c)(1) Inform staffing decisions to ensure that there are a sufficient number of staff with the appropriate competencies and skill sets necessary to care for its residents' needs as identified through resident assessments and plans of care as required in § 483.35(a)(3).	F 0838		

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F 0838 SS=D	Continued from page 172 §483.71(c)(2) Consider specific staffing needs for each resident unit in the facility and adjust as necessary based on changes to its resident population. §483.71(c)(3) Consider specific staffing needs for each shift, such as day, evening, night, and adjust as necessary based on any changes to its resident population. §483.71(c)(4) Develop and maintain a plan to maximize recruitment and retention of direct care staff. §483.71(c)(5) Inform contingency planning for events that do not require activation of the facility's emergency plan, but do have the potential to affect resident care, such as, but not limited to, the availability of direct care nurse staffing or other resources needed for resident care. This REQUIREMENT is not met as evidenced by:	F 0838		

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F 0838 SS=D	Continued from page 173 Based on clinical record review, staff interviews and review of the facility's assessment it was determined that the facility failed to implement and document a complete facility wide assessment, which identified the specific resources necessary to care for its specific resident population. Findings include: Review of the clinical record revealed that Resident R811 was admitted to the facility on 1/29/25. Review of Resident 811's MDS (Minimum Data Set, periodic assessment of resident care needs) dated 2/5/25, indicated diagnoses of alcoholic cardiomyopathy (the heart is unable to pump blood efficiently, leading to heart failure from prolonged alcohol consumption), sarcoidosis of lung (autoimmune disease where the immune system starts attacking the body, forming small inflammatory lumps called granulomas), and depression. Review of Resident R811's Nursing admission	F 0838		

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F 0838 SS=D	Continued from page 174 evaluation dated 1/29/25, indicated Section H Cardiac/circulation - irregular rate. Section L Skin indicated chest - Life Vest. Review of Resident R811's physician order dated 1/30/25, indicated check Life Vest placement and battery daily. Change battery daily for Life Vest one time a day. Review of the Facility Assessment dated January 2025, failed to include the use of a Life Vest as a condition that requires complex medical care and management routinely cared for in the facility. Interview on 2/13/25, at 2:43 p.m. the Nursing Home Administrator confirmed the facility failed to implement and document a complete facility wide assessment, which identified the specific resources necessary to care for its specific resident population. 28 Pa. Code: 207.2(a) Administrator's responsibility.	F 0838		

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F 0838 SS=D	Continued from page 175	F 0838		
F 0841 SS=F	483.70(g)(1)(2) Responsibilities of Medical Director §483.70(g) Medical director. §483.70(g)(1) The facility must designate a physician to serve as medical director. §483.70(g)(2) The medical director is responsible for- (i) Implementation of resident care policies; and (ii) The coordination of medical care in the facility. This REQUIREMENT is not met as evidenced by:	F 0841	1. A letter was submitted to the Department informing them of a change in medical director. 2. The NHA will review at least quarterly any administrative changes that might require notification to the Department and notify the Department timely.	Completion Date: **03/10/2025** Status: **APPROVED** Date: **02/28/2025**

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F 0841 SS=F	Continued from page 176 Based on review of facility documents, and staff interviews it was determined the facility failed to designate a physician to serve as medical director. Findings Include: Review of the facility's medical director contract dated 1/1/21, indicated Doctor of Osteopathic Medicine (DO), Employee E40 is the President and CEO of a group that is responsible for medical directorship services of the facility. Review of information submitted to the Department of Health, on 2/13/25, at 1:30 p.m. revealed Medical Director, Employee E38 was the designated Medical Director of the facility since 9/1/16. Review of the facility's emergency preparedness plan on 2/13/25, at 1:32 p.m. revealed DO, Employee E40 was the Medical Director. During an interview on 2/13/25, at 1:41 p.m. the	F 0841		

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F 0841 SS=F	Continued from page 177 Nursing Home Administrator (NHA) indicated Medical Director, Employee E38 has not been the Medical Director since he's been here. It was indicated Medical Director, Employee E38 was the medical director before 2023, and Medical Director, Employee E39 took over the beginning of 2024. NHA stated when Medicare/Medicaid recertifications were submitted, Medical Director, Employee E39 was listed. During an interview on 2/13/25, at 1:47 p.m. the NHA stated multiple people are the Medical Director and the facility uses a group. The NHA confirmed the facility failed to designate a physician to serve as medical director. During an interview on 2/13/25, at 2:09 p.m. the Director of Nursing stated DO, Employee E40 is not in the building much, and he delegated the Medical Director role to Medical Director, Employee E39. The DON indicated Medical Director, Employee E39 is the acting Medical Director, and he is the one who attends Quality	F 0841		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395015	A. BLDG: __00_____ B. WING: _____	02/14/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
BRIGHTON REHABILITATION AND WELLNESS CENTER STATE LICENSE NUMBER: **020802**	**246 FRIENDSHIP CIRCLE BEAVER, PA 15009**

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F 0841 SS=F	Continued from page 178 Assurance and Performance Improvement (QAPI) meetings. During an interview on 2/14/25, at 9:55 am. Medical Director, Employee E39 stated he works for a medical group under DO, Employee E40 and functions as the facility's medical director. It was indicated he started coming to the facility in October 2023. 28 Pa. Code 211.2.(d) Medical director.	F 0841		
F 0847 SS=D		F 0847		

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F 0847 SS=D	Continued from page 179 483.70(m)(1)(2)(i)(ii)(3)-(5) Entering into Binding Arbitration Agreements §483.70(m) Binding Arbitration Agreements If a facility chooses to ask a resident or his or her representative to enter into an agreement for binding arbitration, the facility must comply with all of the requirements in this section. §483.70(m)(1) The facility must not require any resident or his or her representative to sign an agreement for binding arbitration as a condition of admission to, or as a requirement to continue to receive care at, the facility and must explicitly inform the resident or his or her representative of his or her right not to sign the agreement as a condition of admission to, or as a requirement to continue to receive care at, the facility. §483.70(m)(2) The facility must ensure that: (i) The agreement is explained to the resident and his or her representative in a form and manner that he or she understands, including in a language the resident and his or her representative understands; (ii) The resident or his or her representative acknowledges that he or she understands the agreement; §483.70(m)(3) The agreement must explicitly grant the resident or his or her representative the right to rescind the agreement within 30 calendar days of signing it.	F 0847	1. A binding arbitration agreement was sent to R428's emergency contact. A binding arbitration agreement was sent to R300's. 2. The New Admissions Director audited the last 30 days of admissions to ensure residents who admitted and signed arbitration agreements understood, per the regulation. 3. The New Admissions Director was re in serviced by the NHA to ensure residents who admit and review the arbitration agreement are explained in a manner they can understand per the regulation. 4. The New Admission Director will audit admissions for the next 30 days to ensure residents who admit and review the arbitration agreement are explained in a manner they can understand per the regulation. Audit findings will be shared by the QAPI committee.	Completion Date: **03/10/2025** Status: **APPROVED** Date: **02/28/2025**

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F 0847 SS=D	Continued from page 180 §483.70(m)(4) The agreement must explicitly state that neither the resident nor his or her representative is required to sign an agreement for binding arbitration as a condition of admission to, or as a requirement to continue to receive care at, the facility. §483.70(m)(5) The agreement may not contain any language that prohibits or discourages the resident or anyone else from communicating with federal, state, or local officials, including but not limited to, federal and state surveyors, other federal or state health department employees, and representative of the Office of the State Long-Term Care Ombudsman, in accordance with §483.10(k). This REQUIREMENT is not met as evidenced by:	F 0847		

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F 0847 SS=D	Continued from page 181 Based on review of facility documents, resident clinical records and staff interviews it was determined that the facility failed to ensure residents had the capacity to understand the terms of a binding arbitration agreement (A binding agreement by the parties to submit to arbitration all or certain disputes which have arisen or may arise between them in respect of a defined legal relationship, whether contractual or not.) for two of five residents (Residents R300, and R428). Findings include: Review of the admission record indicated Resident R300 was admitted to the facility on 6/27/24. Review of Resident R300's Binding Arbitration Agreement indicated that the resident signed the document on 6/28/24. Review of Resident R300's Minimum Data Set (MDS - a periodic assessment of care needs) dated 7/4/24, indicated the diagnoses of Non-Alzheimer '	F 0847		

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F 0847 SS=D	Continued from page 182 s Dementia (dementia caused by other diseases with symptoms forgetfulness, limited social skills, and impaired thinking abilities that interfere with daily functioning), weight loss, and depression. Section C0500 BIMS (Brief Interview for Mental Status - a screening test that aides in detecting cognitive impairment) indicated a score of 3 (score of 0 -7 indicates severe cognitive impairment. Review of the admission record indicated Resident R428 was admitted to the facility on 11/5/24. Review of Resident R428's Binding Arbitration Agreement indicated that the resident signed the document on 11/6/24. Review of Resident R428's MDS dated 11/12/24, indicated the diagnoses of Non-Alzheimer ' s Dementia, diabetes (a long-term condition in which the body has trouble controlling blood sugar and using it for energy), and high blood pressure. Section C0500 BIMS (Brief Interview for Mental Status - a screening test that aides in detecting	F 0847		

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F 0847 SS=D	Continued from page 183 cognitive impairment) indicated a score of 0 (score of 0 -7 indicates severe cognitive impairment. Interview on 2/14/25, at 10:17 a.m. Admission Director, Employee E21 confirmed the facility failed to ensure a resident had the capacity to understand the terms of a binding arbitration agreement for two of five residents (Residents R300, and R428). 28 Pa. Code: 201.14(a)(c)(d)(e) Responsibility of licensee. 28 Pa. Code: 201.18(e)(1) Management	F 0847		
F 0868 SS=D		F 0868		

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F 0868 SS=D	Continued from page 184 483.75(g)(1)(i)-(iii)(2)(i); 483.80(c) QAA Committee §483.75(g) Quality assessment and assurance. §483.75(g) Quality assessment and assurance. §483.75(g)(1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and (iv) The infection preventionist. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (i) Meet at least quarterly and as needed to coordinate and evaluate activities under the QAPI program, such as identifying issues with respect to which quality assessment and assurance activities, including performance improvement projects required under the QAPI program, are necessary. §483.80(c) Infection preventionist participation on quality assessment and assurance committee. The individual designated as the IP, or at least one of the individuals if there is more than one IP, must be a member	F 0868	Infection preventionist reviewed QA data from Q3 of 2024. Medical director reviewed data from Q1 of 2024. 2. An audit was done of QA attendance logs for 2024 to ensure all required persons were in attendance. 3. Director of nursing or designee will in-service required persons for QA meeting on meeting schedule and required attendance. 4. Director of nursing or designee will audit attendance sheets quarterly to ensure attendance of required persons. Audit findings will be shared with QAPI committee.	Completion Date: **03/10/2025** Status: **APPROVED** Date: **02/28/2025**

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F 0868 SS=D	Continued from page 185 of the facility's quality assessment and assurance committee and report to the committee on the IPCP on a regular basis. This REQUIREMENT is not met as evidenced by:	F 0868		

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F 0868 SS=D	Continued from page 186 Based on review of facility policy, Quality Assurance attendance records, and staff interview, it was determined that the facility failed to conduct Quality Assessment and Assurance (QAA) meetings at least quarterly with all of the required committee members for two of four quarters (January 2024 through March 2024, and July 2024 through September 2024). Findings include: Review of facility policy "Quality Assurance Performance Improvement (QAPI)" dated 10/1/24, indicated that the facility will conduct quality assurance/improvement and assessment committee meeting at least quarterly to identify areas of service that are non-compliant, or with potential for improvement. Members include Administrator, Director Nursing, Physician, Pharmacy Consultant, three additional members that may include Nutrition. Environmental Services, Social Services, Activities, medical Records, Plant Operations, Human Resources, Rehabilitation.	F 0868		

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F 0868 SS=D	Continued from page 187 A review of the QAPI Committee meeting sign-in sheets from the period of January 2024 through March 2024, did not reveal that the Medical Director was in attendance. A review of the QAPI Committee meeting sign-in sheets from the period of July 2024 through September 2024, did not reveal that the Infection Preventionist was in attendance. During an interview on 2/14/25, at 10:44 a.m. the Director of Nursing confirmed that the facility failed to conduct QAA meetings at least quarterly with all of the required committee members as required. 28 Pa Code: 201.18(e)(1)(2)(3)(4) Management.	F 0868		
F 0880 SS=D		F 0880		

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F 0880 SS=D	Continued from page 188 483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported;	F 0880	1. Root cause analysis will be conducted with facility infection control committee to determine barriers to compliance with enhanced barrier precautions. 2. Infection preventionist completed the Nursing Home Infection Preventionist Training Course through the CDC. 3. Facility contracted with Core Tactics to conduct on-site in-servicing for infection control on 3/11/25-3/12/2025. Education will include policy and procedure for enhanced barrier precautions. Director of nursing or designee will educate nursing staff facility on enhanced barrier precaution policy and procedure. 4. Director of nursing or designee will audit 5 staff members daily for 30 days to ensure proper ppe use, handling of soiled linen, sharps and biohazardous material, and handwashing. Audits will occur twice weekly thereafter for and additional 30 days. Audit findings will be shared with QAPI committee.	Completion Date: **03/13/2025** Status: **APPROVED** Date: **03/05/2025**

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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F 0880 SS=D	Continued from page 189 (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by:	F 0880		

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F 0880 SS=D	Continued from page 190	F 0880		

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F 0880 SS=D	Continued from page 191 Based on facility policy, clinical record review, observation, and staff interview, it was determined that the facility failed to follow enhanced barrier precautions for one of five residents (Residents R367). Findings include: Review of the facility policy "Enhanced Barrier Precautions" dated 10/1/24, indicated enhanced barrier precautions (EBP) are in place for residents with an infection or colonization of a multi-drug-resistant organism (MDRO), wounds and/or indwelling medical devices. Gowns and gloves are to be on and used when providing high contact care with a resident who is in EBP. Review of the clinical record indicated Resident R367 was admitted to the facility on 9/19/24. Review of Resident R367's Minimum Data Set (MDS - a periodic assessment of care needs) dated 2/2/25, indicated diagnoses of neurogenic bladder	F 0880		

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F 0880 SS=D	Continued from page 192 (lack of bladder control due to a brain, spinal cord or nerve problem), paraplegia (paralysis of legs and lower body), and depression. Review of Resident R367's physician order dated 1/29/25, indicated EBP. Resident with presence of suprapubic catheter, colostomy, and wound. Staff to wear gloves and gown for high contact resident care: dressing, bathing, transferring, changing linen, toileting/hygiene care device/line care, and wound care. Review of Resident R367's care plan dated 1/3/25, indicated resident with presence of colostomy, suprapubic catheter, and wound requiring EBP. Observation on 2/10/25, at 1:29 p.m. Resident R367's door was adorned with EBP signage. Observation on 2/10/25, at 1:30 p.m. Resident R367 was receiving direct personal hygiene care from Nurse Aide (NA) Employee E25. NA Employee E25 failed to have a gown on as required	F 0880		

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F 0880 SS=D	Continued from page 193 for EBP. Interview on 2/10/25, at 1:30 p.m. NA Employee E25, confirmed she did not have a gown on as required for EBP. Observation on 2/11/25, at 9:09 a.m. Wound Care Registered Nurse (RN) Employee E3 was observed providing direct wound care with another staff member. Neither staff member had a gown on as required for EBP. Interview on 2/11/25, at 9:10 a.m. Wound Care RN Employee E3 confirmed that neither staff had a gown on as required for EBP. Interview on 2/14/25, at 3:00 p.m. the Director of Nursing confirmed the facility failed to follow enhanced barrier precautions as required for one of five residents (Residents R367). 28 Pa. Code 201. 18(b)(1) Management. 28 Pa code:211.10(c)(d) Resident care policies.	F 0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395015	A. BLDG: __00_____ B. WING: _____	02/14/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
BRIGHTON REHABILITATION AND WELLNESS CENTER STATE LICENSE NUMBER: **020802**	**246 FRIENDSHIP CIRCLE BEAVER, PA 15009**

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F 0880 SS=D	Continued from page 194 28 Pa. Code: 211.12(c)(d)(1)(3)(5) Nursing services	F 0880		
F 0883 SS=D		F 0883		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395015	A. BLDG: 00 B. WING:	02/14/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
BRIGHTON REHABILITATION AND WELLNESS CENTER STATE LICENSE NUMBER: **020802**	**246 FRIENDSHIP CIRCLE BEAVER, PA 15009**

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F 0883 SS=D	Continued from page 195 483.80(d)(1)(2) Influenza and Pneumococcal Immunizations §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization;	F 0883	1. Signed declination forms were obtained for R133 and R101. 2. Infection preventionist will do an audit of residents in the last 30 days to ensure influenza and Pneumococcal vaccine was offered if indicated and documented. 3. Director of nursing or designee will in-service licensed staff on offering influenza and pneumococcal vaccines and placing completed consent/declination forms in permanent medical record. 4. Director of nursing or designee will audit 5 residents weekly for 2 weeks, then 3 residents weekly for 2 weeks, then 3 residents monthly for 2 months to ensure signed consent/declination is present for influenza and pneumococcal vaccines. Audit findings will be shared with QAPI committee.	Completion Date: **03/10/2025** Status: **APPROVED** Date: **02/28/2025**

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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F 0883 SS=D	Continued from page 196 (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by:	F 0883		

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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F 0883 SS=D	Continued from page 197 Based on facility policy, clinical record review and staff interview, it was determined that the facility failed to provide accurate and timely documentation related to the Influenza and Pneumonia vaccine for two of six residents (Resident R101, and R133). Findings include: Review of facility policy "Resident Immunizations" dated 10/1/24, indicated that Pneumovax and influenza immunizations will be offered to residents. Purpose is to prevent transmission of pneumococcal pneumonia, influenza, and other agents as indicated. Pneumovax should be offered to all residents who have never received the vaccine, who have unknown status of vaccine, and those over age 65. Influenza vaccine is offered September through April of each year. Review of the clinical record indicated Resident R101 was admitted to the facility on 5/9/19. Review of Resident R101's Minimum Data Set	F 0883		

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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F 0883 SS=D	Continued from page 198 (MDS - a periodic assessment of care needs) dated 12/9/24, indicated diagnoses of high blood pressure, anemia (too little iron in the body causing fatigue), and arthritis. MDS Section O0250 Influenza marked 4 - offered but declined. MDS Section O0300 Pneumococcal Vaccine marked 2 - offered but declined. During a review of Resident R101's clinical record on 2/13/25, at 1:00 p.m. indicated that the Pneumonia and Influenza vaccination was refused. During a review of Resident R101's clinical record on 2/13/25, at 1:05 p.m. failed to include documentation of Pneumonia and Influenza vaccination refusal consent form, and that education was provided to Resident R101. Review of the clinical record indicated that Resident R133 was admitted to the facility on 11/23/20. Review of Resident R133's MDS dated 1/19/25, included diagnoses of high blood pressure, chronic	F 0883		

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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F 0883 SS=D	Continued from page 199 pain, and visual loss. MDS Section O0250 Influenza marked 4 - offered but declined. MDS Section O0300 Pneumococcal Vaccine marked 3 - not offered. During a review of Resident R133's clinical record on 2/13/25, at 1:10 p.m. indicated that the Influenza vaccination was refused, and the pneumonia vaccination was blank. During a review of Resident R133's clinical record on 2/13/25, at 1:12 p.m. failed to include documentation of pneumonia vaccination consent form, influenza declined consent form, and that education was provided to Resident R133. During an interview on 2/13/25, at 1:15 p.m. Infection Preventionist Employee E15 confirmed that the facility failed to provide accurate and timely documentation related to the Influenza and Pneumonia vaccine for two of six residents (Resident R101, and R133).	F 0883		

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F 0883 SS=D	Continued from page 200 28 Pa. Code 211.5(f) Clinical records	F 0883		
F 0887 SS=D	483.80(d)(3)(i)-(vii) COVID-19 Immunization §483.80(d) (3) COVID-19 immunizations. The LTC facility must develop and implement policies and procedures to ensure all the following: (i) When COVID-19 vaccine is available to the facility, each resident and staff member is offered the COVID-19 vaccine unless the immunization is medically contraindicated or the resident or staff member has already been immunized; (ii) Before offering COVID-19 vaccine, all staff members are provided with education regarding the benefits and risks and potential side effects associated with the vaccine; (iii) Before offering COVID-19 vaccine, each resident or the resident representative receives education regarding the benefits and risks and potential side effects associated with the COVID-19 vaccine; (iv) In situations where COVID-19 vaccination requires multiple doses, the resident, resident representative, or staff member is provided with current information regarding those additional doses, including any changes in the benefits or risks and potential side effects associated with the COVID-19 vaccine, before requesting consent for administration of any additional	F 0887	1. Signed declination forms for Covid-19 vaccination were obtained for R133 and R101. 2. Infection preventionist will conduct an audit of admissions for the last 30 days to ensure Consent or declination was signed for covid-19 vaccination. 3. Director of nursing or designee will in-service licensed staff on offering covid-19 vaccines and placing completed consent/declination forms in permanent medical record 4. Director of nursing or designee will audit 5 residents weekly for 2 weeks, then 3 residents weekly for 2 weeks, then 3 residents monthly for 2 months to ensure signed consent/declination forms are present in the medical record. Audit findings will be shared with QAPI committee.	Completion Date: **03/10/2025** Status: **APPROVED** Date: **02/28/2025**

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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F 0887 SS=D	Continued from page 201 doses; (v) The resident, resident representative, or staff member has the opportunity to accept or refuse a COVID-19 vaccine, and change their decision; (vi) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident representative was provided education regarding the benefits and potential risks associated with COVID-19 vaccine; and (B) Each dose of COVID-19 vaccine administered to the resident; or (C) If the resident did not receive the COVID-19 vaccine due to medical contraindications or refusal; and (vii) The facility maintains documentation related to staff COVID-19 vaccination that includes at a minimum, the following: (A) That staff were provided education regarding the benefits and potential risks associated with COVID-19 vaccine; (B) Staff were offered the COVID-19 vaccine or information on obtaining COVID-19 vaccine; and (C) The COVID-19 vaccine status of staff and related information as indicated by the Centers for Disease Control and Prevention's National Healthcare Safety Network (NHSN). This REQUIREMENT is not met as evidenced by:	F 0887		

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F 0887 SS=D	Continued from page 202	F 0887		

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F 0887 SS=D	Continued from page 203 Based on facility policy, clinical record review and staff interview, it was determined that the facility failed to provide accurate and timely documentation related to the COVID-19 (a respiratory infection) vaccine for two of six residents (Resident R101, and R133). Findings include: Review of facility policy "Covid Management Plan" dated 10/1/24, indicated that residents and staff members will be offered the vaccine unless the immunization is medically contraindicated, or the resident or staff member has already been immunized. The resident or resident representative may refuse the vaccine, and may change their decision. Review of the clinical record indicated Resident R101 was admitted to the facility on 5/9/19. Review of Resident R101's Minimum Data Set (MDS - a periodic assessment of care needs) dated	F 0887		

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F 0887 SS=D	Continued from page 204 12/9/24, indicated diagnoses of high blood pressure, anemia (too little iron in the body causing fatigue), and arthritis. MDS section O0350-Covid 19 vaccination, is up to date was marked "0" indicating - no, resident is not up to date. During a review of Resident R101's clinical record on 2/13/25, at 1:00 p.m. indicated that the Covid-19 vaccination was refused. During a review of Resident R101's clinical record on 2/13/25, at 1:05 p.m. failed to include documentation of Covid-19 vaccination refusal consent form, and that education was provided to Resident R101. Review of the clinical record indicated that Resident R133 was admitted to the facility on 11/23/20. Review of Resident R133's MDS dated 1/19/25, included diagnoses of high blood pressure, chronic pain, and visual loss. MDS section O0350-Covid 19 vaccination, is up to date was marked "0"	F 0887		

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F 0887 SS=D	Continued from page 205 indicating - no, resident is not up to date. During a review of Resident R133's clinical record on 2/13/25, at 1:10 p.m. indicated that the Covid-19 vaccination was refused. During a review of Resident R133's clinical record on 2/13/25, at 1:12 p.m. failed to include documentation of Covid-19 vaccination refusal consent form, and that education was provided to Resident R133. During an interview on 2/13/25, at 2:15 p.m. Infection Preventionist Employee E15 confirmed that the facility failed to provide accurate and timely documentation related to the COVID-19 vaccine for two of six residents (Resident R101, and R133). 28 Pa. Code 211.5(f) Clinical records	F 0887		

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F 0908 SS=D	483.90(d)(2) Essential Equipment, Safe Operating Condition §483.90(d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by:	F 0908	1. Resident R761 wheel chair was adjusted to residents' preference and safety. 2. The therapy and maintenance team audited resident wheel chairs to ensure they operated to residents' safety. 3. The Therapy team and Maintenance team were re in serviced to ensure mechanical patient care equipment is in safe working order. 4. The therapy team will audit daily for two weeks to ensure mechanical patient care equipment is in safe working order. Audit findings will be shared by QAPI committee.	Completion Date: **03/10/2025** Status: **APPROVED** Date: **02/28/2025**

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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F 0908 SS=D	Continued from page 207 Based on observations and staff interviews it was determined that the facility failed to make certain that equipment was in safe operating condition for one of six residents (Resident R761). Findings include: Review of facility "Resident Right" policy dated 10/1/24, indicated that the facility will promote the exercise of rights for each resident. The nursing home shall establish and implement written policies and procedures setting forth the right of residents for the protection and preservation of dignity, individuality and, to the extent medically feasible, independence. Review of the clinical record indicated Resident R761 was admitted to the facility on 1/31/25. Review of Resident R761's Minimum Data Set (MDS - a periodic assessment of care needs) dated 2/6/25, indicated diagnoses of high blood pressure, absence of right and left lower legs, diabetes (a	F 0908		

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F 0908 SS=D	Continued from page 208 metabolic disorder in which the body has high sugar levels for prolonged periods of time). MDS Section GG Functional Abilities Admission RR1: Type of wheelchair used was marked "1", indicating a manual wheelchair. During a review of current physician orders on 2/10/25, at 12:05 p.m. indicated resident to be out of bed to manual wheelchair with pressure reduction cushion, bilateral leg rests and anti-rollback safety device in place to reduce fall risk. During Resident R761 interview on 2/10/25, at 1:40 p.m. resident stated, "Look at this wheelchair, the brakes don't even work. I'm afraid if I transfer out of the wheelchair, it will move, and I will fall". During an observation on 2/10/25, at 1:55 p.m. bilateral braking mechanisms were loose, had yellow tape around the handles, and was not in working order. Resident R761 was able to wheel his wheelchair forward while the brakes were engaged.	F 0908		

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F 0908 SS=D	Continued from page 209 During an interview on 2/10/25, at 2:00 p.m. the Licensed Practical Nurse Employee E13 stated "I thought they fixed the brakes. I will call our therapy department to come and see him". During an interview on 2/10/25, at 2:15 the LPN Employee E13 confirmed that the facility failed to make certain that equipment was in safe operating condition for one of six residents (Resident R761). 28 Pa Code: 201.14(a) Responsibility of licensee.	F 0908		
F 0919 SS=D		F 0919		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395015	A. BLDG: 00 B. WING:	02/14/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
BRIGHTON REHABILITATION AND WELLNESS CENTER STATE LICENSE NUMBER: **020802**	**246 FRIENDSHIP CIRCLE BEAVER, PA 15009**

(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 0919 SS=D	Continued from page 210 483.90(g)(1)(2) Resident Call System §483.90(g) Resident Call System The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area from- §483.90(g)(1) Each resident's bedside; and §483.90(g)(2) Toilet and bathing facilities. This REQUIREMENT is not met as evidenced by:	F 0919	1. The call light chord in the 2 east solarium bathroom was replaced and operational. 2. The director of maintenance or designee audited resident bathrooms on 2 east to ensure call light chords were present and operational. 3. The director of maintenance was re in serviced by the NHA to ensure call light chords are present and operational and or a proper intervention is in place in the event of a disruption of service. 4. The director of maintenance will audit daily for one week to ensure call light chords are present and operational. Audits will be shared with QAPI committee	Completion Date: **03/10/2025** Status: **APPROVED** Date: **02/28/2025**

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F 0919 SS=D	Continued from page 211 Based on review of facility policy, observations and staff interview, it was determined that the facility failed to maintain an effective call system for one out of three resident restrooms in the East building (Two East Solarium/ common area restroom). Findings include: The facility "Call lights" policy dated 10/1/24, indicated that a call light system is used by this facility to respond to the resident's requests and needs. Be sure that the call light is plugged in at all times. During an observation on 2/10/25, at 9:38 a.m. of the Two East Solarium/ common area restroom door was observed open with no emergency call light or call cord attached for emergency use. During an observation on 2/12/25, at 9:33 a.m. of the Two East Solarium/ common area restroom door was observed open with no emergency call light or call cord attached for emergency use.	F 0919		

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F 0919 SS=D	Continued from page 212 During an interview on 2/12/25, at 9:35 a.m. the Licensed Practical Nurse (LPN) Supervisor Employee E7 indicated that failed to maintain an effective call system for one out of three resident restrooms in the East building as required. 28 Pa. Code 201.14 (a) Responsibility of licensee 28 Pa. Code 201.18 (b) (1) Management	F 0919		

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H 0009	51.3 (g)(1-14) NOTIFICATION 51.3 Notification (g) For purposes of subsections (e) and (f), events which seriously compromise quality assurance and patient safety include, but not limited to the following: (1) Deaths due to injuries, suicide or unusual circumstances. (2) Deaths due to malnutrition, dehydration or sepsis. (3) Deaths or serious injuries due to a medication error. (4) Elopements. (5) Transfers to a hospital as a result of injuries or accidents. (6) Complaints of patient abuse, whether or not confirmed by the facility. (7) Rape. (8) Surgery performed on the wrong patient or on the wrong body part. (9) Hemolytic transfusion reaction. (10) Infant abduction or infant discharged to the wrong family. (11) Significant disruption of services due to disaster such as fire, storm, flood or other occurrence. (12) Notification of termination of any services vital to continued safe operation of the facility or the	H 0009	1. Report for 2 main call light system was submitted to the department of health via electronic reporting system (#1075769) 2. An audit was conducted of outstanding work orders to ensure any service outages were reported to the department of health. No issues identified. 3. The administrator or designee will in-service the maintenance department on reporting service outages to administration so they can be reported to the department of health in a timely manner. 4. Administrator or designee will audit outstanding work orders weekly for 4 weeks to ensure any service outages are reported to the department of health. Audit findings will be shared with QAPI committee	Completion Date: **03/10/2025** Status: **APPROVED** Date: **02/28/2025**

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

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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H 0009	Continued from page 1 health and safety of its patients and personnel, including, but not limited to, the anticipated or actual termination of electric, gas, steam heat, water, sewer and local exchange of telephone service. (13) Unlicensed practice of a regulated profession. (14) Receipt of a strike notice. This REGULATION is not met as evidenced by:	H 0009		

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H 0009	Continued from page 2 Based on facility reports, and staff interviews it was determined that the facility failed to notify the Department of Health of a disruption of service. Findings include: During a facility tour on 2/10/25 at 10:00 a.m., the 2nd floor, 2 main, revealed all resident's having tap bells. Interview with Unit Manager E29 revealed they haven't been in operation for about a month. During a review of facility provided documentation revealed there was no report submitted to the Department of Health. During an interview on 2/10/25 at 11:00 a.m. Director of Nursing confirmed that the fcaility failed to notify the Department of Health of a disruption of service as required.	H 0009		

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P 1020	Responsibility of licensee. (a) The licensee is responsible for meeting the minimum standards for the operation of a facility as set forth by the Department and by other Federal, State and local agencies responsible for the health and welfare of residents. This includes complying with all applicable Federal and State laws, and rules, regulations and orders issued by the Department and other Federal, State or local agencies. This REGULATION is not met as evidenced by:	P 1020	1. Infection control data for quarters 1 and 3 2024 was reviewed by the medical director. Data from quarters 2, 3 and 4 2024 was reviewed by the consultant pharmacist. Data from quarter 3 2024 was reviewed by the infection preventionist and lab personnel. 2. An audit was done of 2024 infection control committee logs was done to ensure all other required persons were in attendance. 3. Director of nursing or designee will in-service all persons required for infection control committee meetings on meeting scheduled and required attendance. 4. Director of nursing or designee will audit attendance sheets quarterly to ensure all required persons are in attendance. Audit findings will be shared with QAPI committee.	Completion Date: **03/10/2025** Status: **APPROVED** Date: **02/28/2025**

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

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P 1020	Continued from page 1 Based on staff interview, and review of the facility's Infection Control Committee Meeting attendance records, it was determined that the facility failed to ensure that Infection Control meetings had all the required nine multidisciplinary members present at the Infection Control meetings for four of four quarters (Medical Director, Infection Preventionist, lab and pharmacy). Findings include: Review of Act 52 (The Act of March 20, 2002, P.L. 154, No. 13), known as the Medical Care Availability and Reduction of Error (MCARE) Act, Chapter 4, Section 403(1) Infection Control plan states, "A health care facility... shall develop and implement an internal infection control plan that shall include... a multidisciplinary committee including representatives from each of the following if applicable to that specific health care facility." A review of the applicable members at infection control meetings includes medical staff, administration, laboratory personnel, nursing staff,	P 1020		

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P 1020	Continued from page 2 pharmacy staff, physical plan personnel, patient safety officer, a community member, and a member of the infection control team. Review of the facility's Infection Control Committee Meeting attendance log forms from quarter one, failed to reveal that the medical director was in attendance. Review of the facility's Infection Control Committee Meeting attendance log forms from quarter two, failed to reveal that the pharmacy was in attendance. Review of the facility's Infection Control Committee Meeting attendance log forms from quarter three, failed to reveal that the medical director, infection preventionist, lab, and pharmacy were in attendance. Review of the facility's Infection Control Committee Meeting attendance log forms from quarter four, failed to reveal that the pharmacy was in attendance.	P 1020		

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P 1020	Continued from page 3 During an interview on 2/11/25, at 9:57 a.m. the Infection Preventionist Employee E15 confirmed the facility failed to ensure that Infection Control meetings had all the required nine multidisciplinary members present at the Infection Control meetings for four of four quarters (Medical Director, Infection Preventionist, lab and pharmacy), as required.	P 1020		
P 3310		P 3310		

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P 3310	Continued from page 4 Resident bedrooms. (a) A bed for a resident shall be placed only in a bedroom approved by the Department. This REGULATION is not met as evidenced by:	P 3310	1. A correct Roster was sent to the department to ensure the Department roster was accurate. Beds that were available were placed in proper locations. In the event a bed was identified in a location that it shouldn't be it was removed. Beds were removed in the event they required repair to be re-placed upon repair or replacement. East 3 - 340, 342, 343, 347, 357 will have one bed returned upon repair or replacement East 4 - 442, 450 will have one bed returned upon repair or replacement Grove 1 - 104, 105, 106, 117 will have one bed returned upon repair or replacement Grove 2 - 202, 203, 205, 209, 215 will have one bed returned upon repair or replacement grove 306, 307, 309, 314, 315, 316, 317 will have one bed returned upon repair or replacement	Completion Date: **03/10/2025** Status: **APPROVED** Date: **03/03/2025**

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P 3310	Continued from page 5	P 3310	West 103, 107 will have one bed returned upon repair or replacement West 270 will have one bed returned upon repair or replacement West 3rd floor was / is used as an isolation unit in the event of a mass population requiring isolation. all rooms have correct number of beds in rooms, unless beds require repair and will be replaced upon repair. main 306, 312 will have one bed returned upon repair or replacement main 405, 411, 416, 428, 430 will have one bed returned upon repair or replacement Main 504, 523, 527, 530 will have one bed returned upon repair or replacement 2. The NHA reviewed the bed roster to ensure resident rooms were fitted to the proper number of resident beds.	

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P 3310	Continued from page 6	P 3310	3. The NHA will review the roster quarterly to ensure resident rooms are fitted to the proper number of resident beds.	

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P 3310	Continued from page 7 Based on review of approved bed information, observations, and staff interview, it was determined that the facility failed to obtain the Department of Health's approval prior to removing beds from resident bedrooms. Findings include: During observations on all nursing units on 2/10/25, through 2/13/25 the following were observed: East Wing- Third Floor: Room 340 - licensed for four beds - had three beds. Room 342 - licensed for four beds - had three beds. Room 343 - licensed for four beds- had two beds. Room 347 - licensed for two beds - had one bed. Room 357 - licensed for two beds - had one bed. East Wing- Fourth Floor: Room 442 - licensed for two beds - had one bed. Room 450 - licensed for four beds - had three	P 3310		

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P 3310	Continued from page 8 beds. Grove- First Floor: Room 104 - licensed for two beds - had one bed. Room 105- licensed for two beds - had one beds. Room 106- licensed for two beds - had one bed. Room 117 - licensed for two beds - had one bed. Grove- Second Floor: Room 202 - licensed for two beds - had one bed. Room 203 - licensed for two beds - had one bed. Room 205 - licensed for two beds - had one bed. Room 209 - licensed for two beds - had one bed. Room 215 - licensed for two beds - had one bed. Grove- Third Floor: Room 306- licensed for two beds- had one bed. Room 307- licensed for two beds- had one bed. Room 309- licensed for two beds- had one bed. Room 314- licensed for two beds- had one bed. Room 315- licensed for two beds- had one bed. Room 316- licensed for two beds- had one bed. Room 317- licensed for two beds- had zero beds.	P 3310		

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P 3310	Continued from page 9 West Wing- First Floor: Room 103- licensed for two beds- had one bed. Room 107- licensed for two beds- had one bed. West Wing- Second Floor: Room 270- licensed for two beds- had one bed. West Wing- Third Floor: Note that zero complete beds were on this unit. Rooms contained only bed frames without mattresses or furniture. Room 361- licensed for one bed- had zero complete beds. Room 362- licensed for four beds- had zero complete beds. Room 363- licensed for four beds- had zero complete beds. Room 363- licensed for four beds- had zero complete beds. Room 365- licensed for four beds- had zero complete beds. Room 366- licensed for four beds- had zero	P 3310		

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P 3310	Continued from page 10 complete beds. Room 367- licensed for four beds- had zero complete beds. Room 368- licensed for two beds- had zero complete beds. Room 369- licensed for four beds- had zero complete beds. Room 371- licensed for one bed- had zero complete beds. Room 374- licensed for four beds- had zero complete beds. Room 375- licensed for two beds- had zero complete beds. Room 376- licensed for four beds- had zero complete beds. Room 377- licensed for four beds- had zero complete beds. Room 379- licensed for four beds- had zero complete beds. Room 380- licensed for four beds- had zero complete beds. Room 381- licensed for four beds- had zero complete beds.	P 3310		

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BRIGHTON REHABILITATION AND WELLNESS CENTER STATE LICENSE NUMBER: **020802**	**246 FRIENDSHIP CIRCLE BEAVER, PA 15009**

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P 3310	Continued from page 11 Room 383- licensed for one bed- had zero complete beds. Main- Third Floor: Room 306- licensed for four beds- had three beds. Room 312- licensed for four beds- had three beds. Main- Fourth Floor: Room 405- licensed for four beds- had three beds. Room 411- licensed for four beds- had three beds. Room 416- licensed for four beds- had three beds. Room 428- licensed for two beds- had one bed. Room 430- licensed for two beds- had one bed. Main- Fifth Floor: Room 504- licensed for four beds- had two beds. Room 523- licensed for two beds- had one bed. Room 527- licensed for two beds- had one bed. Room 530- licensed for two beds- had one bed. During an interview on 2/13/25, at 2:50 p.m. the Nursing Home Administrator confirmed that the facility failed to obtain the Department of Health's	P 3310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395015	A. BLDG: __00_____ B. WING: _____	02/14/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
BRIGHTON REHABILITATION AND WELLNESS CENTER STATE LICENSE NUMBER: **020802**	**246 FRIENDSHIP CIRCLE BEAVER, PA 15009**

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P 3310	Continued from page 12 approval prior to removing beds from resident bedrooms.	P 3310		
P 3330		P 3330		

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 3330	Continued from page 13 Resident bedrooms. (c) The number of resident bedrooms and the number of beds in a room may not exceed the maximum number approved by the Department. This REGULATION is not met as evidenced by:	P 3330	1. Bed read out was reviewed and corrected and sent to the Department to ensure the Department roster was and facility layout matched . Beds that were available were placed in active room locations. In the event a bed was identified in a location that it shouldn't be it was removed. Beds that require repair are removed from resident rooms and returned on either repair or replacement. Grove 318 - corrected doh bed read out with active room main 210 - corrected doh bed read out - 4 active beds remain main 303, 316, 317, 318, 323 corrected doh bed read out - 4 active beds remain main 326, 327 corrected do bed read out - 2 active beds remain main 324 made a bed inactive in electronic medical record to comply with having the correct number of	Completion Date: **03/10/2025** Status: **APPROVED** Date: **03/12/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395015	A. BLDG: __00_____ B. WING: _____	02/14/2025

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P 3330	Continued from page 14	P 3330	licensed beds available. 2. Plant ops director was in serviced by NHA to ensure to replace or repair beds or items to return to empty rooms as soon as practicable to ensure availability and use to meet the number of licensed beds. 3. The NHA will review the roster quarterly to ensure resident rooms are fitted with the proper number of resident beds to meet the number of licensed beds.	

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 3330	Continued from page 15 Based on review of approved bed information, observations, and staff interview, it was determined that the facility failed to obtain the Department of Health's approval prior to adding beds to resident bedrooms. Findings include: During observations on all nursing units on 2/10/25, through 2/13/25 the following were observed: Grove- Third Floor: Room 318- Not on Bed Readout- had two beds. Main- Second Floor: Room 210- licensed for three beds- had four beds. Main- Third Floor: Room 303- licensed for three beds- had four beds. Room 316- licensed for two beds- had four beds. Room 317- licensed for three beds- had four beds. Room 318- licensed for three beds- had four beds. Room 323- licensed for one bed- had two beds.	P 3330		

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 3330	Continued from page 16 Room 324- licensed for one bed- had two beds. Room 326- licensed for one bed- had two beds. Room 327- licensed for one bed- had two beds. Main- Fourth Floor: Room 409- licensed for three beds- had four beds. Room 418- licensed for three beds- had four beds. Main- Fifth Floor: Room 512- licensed for three beds- had four beds. During an interview on 2/13/25, at 2:50 p.m. the Nursing Home Administrator confirmed that the facility failed to obtain the Department of Health's approval prior to adding beds to resident bedrooms.	P 3330		

Certified End Page

BRIGHTON REHABILITATION AND WELLNESS CENTER

STATE LICENSE NUMBER: 020802

SURVEY EXIT DATE: 02/14/2025

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