STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395146	A. BLDG: __00_____ B. WING: _____	01/10/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
CANTERBURY PLACE STATE LICENSE NUMBER: **050702**	**310 FISK STREET PITTSBURGH, PA 15201**

(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	F 0000		

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 0000	Continued from page 1 Based on a Medicare/Medicaid Recertification survey, State Licensure survey, Civil Rights Compliance survey completed on January 10, 2025, it was determined that Canterbury Place was not in compliance with the following requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities and the 28 PA Code, Commonwealth of Pennsylvania Long Term Care Licensure Regulations.	F 0000		

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F 0607 SS=E	483.12(b)(1)-(5)(ii)(iii) Develop/Implement Abuse/Neglect Policies §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, §483.12(b)(4) Establish coordination with the QAPI program required under §483.75. §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements. §483.12(b)(5)(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act. §483.12(b)(5)(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act. This REQUIREMENT is not met as evidenced by:	F 0607	The facility obtained satisfactory criminal records checks (state background checks, PATCH) on new employees hired in the last four months including employees E-2, E-17, E-18, E-19, and E-20. Human Resources and the In-service coordinator have been re-educated on the importance of securing a satisfactory criminal records check (state background checks, PATCH) on all new employees prior to the employees' first day at the facility. All new hire paperwork including the satisfactory criminal records check (state background checks, PATCH) will be audited by the administrator or designee every two weeks for two months prior to the start of orientation to ensure that all new employees have a satisfactory criminal records check (state background checks, PATCH) Any deficient practice will be immediately corrected. All data will be forwarded to the QAPI committee and the need for additional monitoring will be determined by the committee	Completion Date: **02/28/2025** Status: **APPROVED** Date: **01/28/2025**

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F 0607 SS=E	Continued from page 3 Based on review of facility policy, employee personnel records, and staff interview, it was determined that the facility failed to implement their written procedures to prohibit and prevent abuse, neglect, and exploitation of residents by failing to perform criminal history background checks prior to the date of hire for five of six sampled records (Registered Nurse (RN) Employee E2, Nurse Aide (NA) Employee E17, Licensed Practical Nurse (LPN) Employee E18, NA Employee E19, and RN Employee E20). Findings include: The "Safety-01 Abuse, Neglect, Exploitation general policy" dated 5/1/22, last reviewed 1/3/24, indicated that the facility will obtain criminal and FBI background checks. Prior to the employee's first day of employment, the facility will make reasonable efforts to obtain personal and professional reference information. Documentation will note conducted attempts.	F 0607		

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F 0607 SS=E	Continued from page 4 Review of Registered Nurse (RN) Employee E2's was hired to the facility on 9/3/24. Review of Registered Nurse (RN) Employee E2's personnel record did not include a copy of the employee's State background check. Review of nurse deployment documents (a document indicating the name and number of nursing staff working a specific date), indicated that Registered Nurse (RN) Employee E2 worked 9/17/24, and was no longer on orientation. She continued to work for the facility. Review of Nurse Aide (NA) Employee E17 was hired to the facility on 10/24/24. Review of Nurse Aide (NA) Employee E17 personnel record did not include a copy of the employee's State background check. Review of nurse deployment documents, indicated that Nurse Aide (NA) Employee E17 worked	F 0607		

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F 0607 SS=E	Continued from page 5 10/21/24, and was no long on orientation. NA Employee E17 continued to work for the facility. Review of Licensed Practical Nurse (LPN) Employee E18 was hired to the facility on 11/18/24. Review of Licensed Practical Nurse (LPN) Employee E18 personnel record did not include a copy of the employee's State background check. Review of nurse deployment documents, indicated that Licensed Practical Nurse (LPN) Employee E18 worked on 11/29/24, and was no longer on orientation. LPN continued to work for the facility. Review of NA Employee E19 was hired to the facility on 10/28/24. Review of NA Employee E19 personnel record did not include a copy of the employee's State background check. Review of nurse deployment documents, indicated	F 0607		

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F 0607 SS=E	Continued from page 6 that NA Employee E19 worked on 11/04/24, and was no longer on orientation. NA continued to work for the facility. Review of RN Employee E20 was hired to the facility on 11/11/24. Review of RN Employee E20 personnel record did not include a copy for the employee's State background check. Review of nurse deployment documents, indicated that RN Employee E20 worked on 11/19/24, and was no longer on orientation. RN continued to work for the facility. During an interview on 1/10/25, at 1:12 p.m. the Nursing Home Administrator (NHA) confirmed that the facility failed to implement their written procedures to prohibit and prevent abuse, neglect, and exploitation of residents by failing to perform criminal history background checks prior to the date of hire for Registered Nurse (RN) Employee E2 as required, Nurse Aide (NA) Employee E17, Licensed Practical Nurse (LPN) Employee E18,	F 0607		

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F 0607 SS=E	Continued from page 7 NA Employee E19, and RN Employee E20). 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18(b)(1) Management 28 Pa. Code 201.19(3) Personnel policies and procedures	F 0607		

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F 0610 SS=D		F 0610		

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F 0610 SS=D	Continued from page 9 483.12(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	An incident report will be filed in our internal risk master system regarding the medications being found at the bedside for resident R-77. The resident's provider was also made aware. If possible, it will be determined if the medications were facility based or were previously in the possession of the resident, the Medication administration record will be reviewed for accuracy and staff interviews conducted to possibly learn the origin of these medications. No untoward effects were demonstrated by the resident at the time of discovery. All incidents will be reviewed on an at least weekly basis by the DON and/or NHA to ensure timely and complete submission of all pertinent facts. Incidents will be reviewed more immediately if the situation is more acute. Nursing staff (RNs, LPNs and Unit Managers) will be educated by the Director of Nursing, Staff Educator or designee on the gathering of all pertinent information as part of the investigation of incidents including	Completion Date: **02/28/2025** Status: **APPROVED** Date: **01/28/2025**

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F 0610 SS=D	Continued from page 10	F 0610	complete and accurate documentation of medication administration, and that nursing staff are not permitted to leave medication at the bedside unless directed by the provider and included as part of the care plan. Seven rooms will be checked for medications left in the resident's rooms per week for three weeks and then seven rooms will be checked every two weeks for a period of three weeks. Any deficient practice will be immediately corrected. All data will be forwarded to the QAPI committee and the need for additional monitoring will be determined by the committee.	

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F 0610 SS=D	Continued from page 11 Based on review of facility policy, clinical record, and staff interview it was determined that the facility failed to conduct a thorough investigation for one of three residents (Resident R77). Findings include: Review of facility policy "Abuse Neglect Exploitation General Policy" dated 1/3/25, indicated " Investigation - The facility is responsible for investigating and reporting cases of possible abuse, neglect including involuntary seclusion, exploitation, and misappropriation of property to external agencies in accordance with laws and regulations. Review of facility policy "Abuse Investigation and Reporting, Protection and Response" dated 1/??/25, indicated "skilled nursing facilities are responsible for the investigation and reporting of allegation of abuse, neglect, or misappropriation of a resident's property." Review of Resident R77 clinical record was	F 0610		

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F 0610 SS=D	Continued from page 12 admitted on 11/08/24. Review of Resident R77 MDS (minimum data set - a periodic assessment of resident needs) dated 11/26/24, indicated diagnosis of renal insufficiency (kidneys functioning poorly) and diabetes mellitus (when your blood sugar is to high). During a review of Resident R77 clinical record progress note dated 12/21/24, indicated " 2 cups of meds from different times unknown days found at bedside hidden." During a review of facility documentation a concern form about the incident was noted, but failed to include documentation of the investigation to include - what the pills were, if the pills were the facilities or brought in from outside the facility, if medication that was documented as being taken by resident was noted in the medication found by the bedside, , interviews with staff , etc. During an interview on 1/3/25, at 2:25 p.m. Director	F 0610		

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F 0610 SS=D	Continued from page 13 of Nursing confirmed that the investigation was incomplete and that the facility did not document nor investigate what the medication was, where it came from, complete interviews with staff from various recent shifts and that the facility failed to complete a thorough investigation for Resident R77 medication found by bedside. 28 Pa. Code 201.14(a) (c) (e) Responsibility of licensee. 28 Pa. Code 201.18 (e) (1) Management.	F 0610		
F 0657 SS=D		F 0657		

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F 0657 SS=D	Continued from page 14 483.21(b)(2)(i)-(iii) Care Plan Timing and Revision §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by:	F 0657	The care plans of the affected residents (R8 and R316) were updated during survey to include the continuous glucose monitoring device and the wound vac. All the care plans of residents having either a continuous glucose monitoring device and/or a wound vac were reviewed and /or updated to ensure compliance. RNs, and LPNs, will be educated by the Director of Nursing, In-Service Director and/or designee that care plans should be created and/or updated timely to reflect the current condition of the resident including their use of a continuous glucose monitoring device and/or a wound vac. The facility will audit the care plans of all residents with continuous blood glucose monitoring devices and/or wound vacs weekly for three and then biweekly for three weeks to ensure that the care plans reflect the current needs of the residents utilizing these devices. Any deficient practice will be immediately corrected. All data will	Completion Date: **02/28/2025** Status: **APPROVED** Date: **01/28/2025**

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F 0657 SS=D	Continued from page 15	F 0657	be forwarded to the QAPI committee and the need for additional monitoring will be determined by the committee	

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F 0657 SS=D	Continued from page 16 Based on review of facility policy, clinical records, and staff interview, it was determined the facility failed to update a care plan for two of seven residents (Residents R8 and R316) to accurately reflect the current status of the resident and care needs. Findings include: Review of the facility policy "Care Plans, Comprehensive Person-Centered" dated 1/2/25, indicated the facility must develop a comprehensive Person-Centered Care Plan for each resident that includes measurable objectives and timeframes and describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. Review of the admission record indicated Resident R8 was admitted to the facility on 8/20/24. Review of Resident R8's Minimum Data Set (MDS - a periodic assessment of care needs) dated	F 0657		

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F 0657 SS=D	Continued from page 17 12/23/24, indicated the diagnoses of heart failure, mild cognitive impairment, and anxiety disorder. Review of Resident R8's physician order dated 11/19/24, indicated FreeStyle Libre 3 Reader Device (Continuous Glucose System Receiver) Apply 1 unit transdermally one time a day every 14 days. Review of Resident R8's current care plan on 1/8/25, at 11:55 a.m., failed to include the use, as well as the care and services interventions related to the FreeStyle Libre 3 Continuous Glucose monitoring system. During an interview on 1/8/25, at 2:37 p.m., the Director of Nursing (DON) confirmed that Resident R8's current care plan failed to include the use, and care and service interventions for her FreeStyle Libre 3 Continuous Glucose Monitoring system. Review of the admission record indicated Resident R316 admitted to the facility on 12/4/24.	F 0657		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395146	A. BLDG: __00_____ B. WING: _____	01/10/2025

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F 0657 SS=D	Continued from page 18 Review of Resident R316's MDS dated 12/11/24, indicated the diagnoses of high blood pressure, Multiple Sclerosis (immune system eats away at protective covering of nerve cells), and diabetes(a long-term condition in which the body has trouble controlling blood sugar and using it for energy). Review of Resident R316's physician order dated 12/5/24, indicated Wound Vac (a negative pressure wound therapy device) to sacral (above the tail bone) wound. Wound vac to function at 125mm/hg (millimeters of mercury) continuously. Change on Monday, Wednesday, Friday, and as needed for displacement. Review of Resident R316's current plan of care on 1/10/25, at 9:24 a.m. failed to include the wound vac to the sacral wound. Interview on 1/10/25, at 10:00 a.m. the Director of Nursing (DON) confirmed Resident R316's care plan failed to include the wound vac to the sacral	F 0657		

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F 0657 SS=D	Continued from page 19 wound as required. Interview on 1/10/25, at 3:00 p.m. the DON confirmed the facility failed to update a care plan for two of seven residents (Residents R8 and R316) to accurately reflect the current status of the resident and care needs. 28 Pa. Code: 211.11 (a).(c)(d) Resident care plan. 28 Pa. Code: 211.12(d)(1)(5) Nursing services.	F 0657		
F 0684 SS=D		F 0684		

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F 0684 SS=D	Continued from page 20 483.25 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	The resident has been discharged from the facility so provider notification was not accomplished. RNs, LPNs, and Unit Managers will be educated by the Director of Nursing, In-Service Director or designee on the necessity of timely provider notification of the resident's blood glucose level pursuant to the provider's order. The facility will audit five random residents' blood glucose levels weekly for three weeks and compare these levels with the provider's order to ensure compliance. Subsequently, the facility will audit five random residents' blood glucose levels for three weeks bi-weekly. Any deficient practice will be immediately corrected. All data will be forwarded to the QAPI committee and the need for additional monitoring will be determined by the committee.	Completion Date: **02/28/2025** Status: **APPROVED** Date: **01/28/2025**

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F 0684 SS=D	Continued from page 21 Based on review of facility policy, clinical records, and staff interview it was determined that the facility failed to notify a physician of abnormal glucose readings as per order for one out of three residents (Resident R108). Findings include: Review of the facility policy "Diabetes - Clinical Protocol" dated 1/2/25, indicated the physician will order desired parameters for monitoring and reporting information related to blood sugar management. The staff will incorporate such parameters into the Medication Administration Record (MAR). Review of the admission record indicated Resident R108 was admitted on 12/11/24. Review of Resident R108's Minimum Data Set (MDS - a periodic assessment of care needs) dated 12/16/24, indicated the diagnoses of benign prostatic hyperplasia (BPH- age related prostate	F 0684		

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F 0684 SS=D	Continued from page 22 gland enlargement that can cause urination difficulties), obstructive uropathy (a structural or functional hindrance of normal urine flow), and diabetes (a long-term condition in which the body has trouble controlling blood sugar and using it for energy). Review of Resident R108's physician orders dated 12/26/24, indicated Insulin Lispro (a short acting, manmade version of human insulin) inject subcutaneously as per sliding scale: if 0 - 140 = 0; 141 - 180 = 1; 181 - 220 = 2; 221 - 260 = 3; 261 - 300 = 4; 301 - 340 = 5; 341+ = 6 >340 administer 6 units and notify the physician. Review of Resident R108's care plan dated 12/30/24, indicated the resident will be free from signs and symptoms of hyperglycemia (elevated	F 0684		

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F 0684 SS=D	Continued from page 23 glucose levels). Monitor, document, and report as needed, any symptoms of hyperglycemia. Review of Resident R108's glucose log indicated the following: 12/30/24, at 5:19 p.m. glucose result was 398. 12/25/24, at 12:02 p.m. glucose result was 415. 12/24/24, at 10:41 a.m. glucose result was 431. 12/17/24, at 8:10 p.m. glucose result was 446. 12/17/24, at 5:13 p.m. glucose result was 374. 12/13/24, at 12:52 p.m. glucose result was 354. Review of Resident R108's progress notes did not include notification to the physician for the glucose levels above 340 as per physician's order. Interview on 1/9/25, at 10:03 a.m. the Director of Nursing confirmed that the facility failed to notify a physician of abnormal glucose readings as per order for Resident R108 as required. 28 Pa. Code: 201.14(a) Responsibility of licensee. 28 Pa. Code 211.12(d)(1)(2)(3)(5) Nursing	F 0684		

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F 0684 SS=D	Continued from page 24 services	F 0684		
F 0686 SS=D		F 0686		

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F 0686 SS=D	Continued from page 25 483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by:	F 0686	The care plans of the affected residents (R51 and R317) were updated to reflect preventive measures for a stage III wound and a right great toe injury. RNs, and LPNs, will be educated by the Director of Nursing, In-Service Director or designee on the importance of including in the clinical record how and injury occurred, its progression, treatment and healing. The facility will audit the care plans of five random residents with wounds and skin issues weekly for three weeks and then bi-weekly for three weeks to ensure that documentation in the clinical record is complete and comprehensive (how the injury occurred, its progression treatment and healing) Any deficient practice will be immediately corrected. All data will be forwarded to the QAPI committee and the need for additional monitoring will be determined by the committee.	Completion Date: **02/28/2025** Status: **APPROVED** Date: **01/28/2025**

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F 0686 SS=D	Continued from page 26 Based on review of facility policy, clinical records, observation, and interviews with staff, it was determined that the facility failed to make certain that residents received the necessary services to prevent/treat pressure ulcers/wounds for two of six residents (Residents R317 and Resident R51). Findings include: Review of the facility policy "Prevention of Pressure Injuries" dated 1/3/24, indicated review the resident's care plan and identify the risk factors as well as the interventions designed to reduce or eliminate those considered modifiable. Use a standardized pressure injury screening tool to determine and document risk factors. Conduct a comprehensive skin assessment. Implement preventative skin care interventions. Select appropriate support surfaces based on the resident's risk factors. Review the interventions and strategies for effectiveness on an ongoing basis. Review of the facility policy "Care Plans,	F 0686		

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F 0686 SS=D	Continued from page 27 Comprehensive Person-Centered" dated 1/3/24, indicates the facility must develop a comprehensive Person-Centered Care Plan for each resident that includes measurable objectives and timeframes, and describes the services that are to be furnished to attain or maintain the resident ' s highest practicable physical, mental, and psychosocial well-being. Review of the admission record indicated Resident R317 was admitted to the facility on 12/18/24. Review of Resident R317's Minimum Data Set (MDS- a periodic assessment of care needs) dated 12/24/24, indicated the diagnoses of atrial fibrillation (irregular heart rhythm), anxiety (intense, excessive, and persistent worry and fear about everyday situations), and Section M indicated Stage 3 pressure injury (full thickness tissue loss). Section GG indicated resident requires substantial/maximal assistance to roll left and right in the bed and required full dependence for sitting to lying flat on the bed and lying to sitting on the side of the bed with no back support.	F 0686		

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F 0686 SS=D	Continued from page 28 Review of Resident R317's Braden Scale for Predicting Pressure Sore Risk dated 1/8/25, indicated a score of 16 - mild risk of developing pressure ulcers. Review of Resident R317's Wound Consult Note dated 12/30/24, indicated right gluteal fold (the horizontal crease of skin at the inferior border of the buttocks) is an acute Stage 3 pressure injury. Pressure ulcer/injury has received a status of not healed. Review of Resident R317's physician orders on 1/9/25, at 9:00 a.m. failed to include preventative measures of a low air loss mattress (prevent pressure ulcers) and to assist resident with turning and repositioning on a routine schedule. Review of Resident R317's care plan dated 12/27/24, indicated bed mobility: the resident is totally dependent on staff for repositioning and turning in bed and as necessary. The care plan	F 0686		

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F 0686 SS=D	Continued from page 29 failed to include care and management of the Stage 3 pressure injury to the right gluteal fold and failed to include use of the low air loss mattress. Review of the admission record indicated Resident R51 was admitted on 2/27/24. Review of Resident R51 MDS, dated 12/6/24 indicated diagnosis of dementia (loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere in daily life) and depression (mood disorder that causes serious persistent feeling of sadness and loss of interest and can interfere with daily life). Review of Resident R51 clinical record progress notes dated 10/15/24, indicated: "Right big toe noted to have increased redness to the tip, potentially as a result of the boot having been too tight. Nursing staff to continue to monitor and call the MD if it does not resolve." Additional progress notes indicated: 10/15/2024,	F 0686		

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F 0686 SS=D	Continued from page 30 "Note Text: 2.5cm round red/ purple area to R Great toe- no drainage, no edema, no open area noted, no s/s of pain with light palpation to area, and res denies discomfort." 10/15/2024,"Purple area of discoloration about 2.5cm on medial aspect of R great toe. NA noticed this She wears soft bunny boots. Unsure if this area was bumped. Will observe for now and observe Will have my CRNP see her tomorrow" Additional review of Resident R51 clinical record failed to include follow up information of area on right great toe. During an interview on 1/8/25, at 10:23 a.m. Registered Nurse RN Employee E21 confirmed that the facility failed to include progression of the injury, how the injury occurred, when it healed or any follow up information and the facility failed to prevent/treat a wound.	F 0686		

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F 0686 SS=D	Continued from page 31 During an interview on 1/9/25, at 9:21 a.m. the Director of Nursing confirmed the facility failed to develop a pressure ulcer care plan, implement preventative measures, and failed to make certain that residents received the necessary services to prevent/treat pressure ulcers/wounds for two of six residents (Residents R317). During an interview on 1/8/25, at 10:23 a.m. Registered Nurse (RN) Employee E21 confirmed that the facility failed to include progression of the injury, how the injury occurred, when it healed or any follow up information. 28 Pa. Code: 201.14(a) Responsibility of licensee. 28 Pa. Code: 211.11 (a).(c)(d) Resident care plan. 28 Pa. Code 211.12(d)(1)(2)(3)(5) Nursing services.	F 0686		

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F 0690 SS=E		F 0690		

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F 0690 SS=E	Continued from page 33 483.25(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 much normal bowel function as possible.	F 0690	The size of the suprapubic catheter, the balloon size and the proper fluid amount were obtained for residents R53, R58, and R316. Also, the catheter drainage bags were covered for residents R58 and R316. RNs, and LPNs, will be educated by the Director of Nursing, In-Service Director and/or designee on adding the size of the suprapubic catheter, the balloon size and the proper fluid amount urinary catheter type and size when entering a suprapubic order. RNs, and LPNs, and CNAs will be educated by the Director of Nursing, In-Service Director and/or designee on covering all the urinary drainage bags with dignity bags. An audit of all residents with a suprapubic catheter will be conducted by the Director of Nursing or designee to ensure the order contains the size of the catheter, the balloon size and the fluid requirements weekly for three weeks and then biweekly for three weeks An audit of all residents with a foley	Completion Date: **02/28/2025** Status: **APPROVED** Date: **01/28/2025**

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NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
CANTERBURY PLACE STATE LICENSE NUMBER: **050702**	**310 FISK STREET PITTSBURGH, PA 15201**

(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 0690 SS=E	Continued from page 34 This REQUIREMENT is not met as evidenced by:	F 0690	will be conducted by the Director of Nursing or designee to ensure that their catheter drainage bags are covered will be conducted weekly for three weeks and then biweekly for three weeks. Any deficient practice will be immediately corrected. All data will be forwarded to the QAPI committee and the need for additional monitoring will be determined by the 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 0690 SS=E	Continued from page 35 Based on review of facility policy, clinical records and staff interview, it was determined that the facility failed to ensure that the physician order for a urinary catheter (insertion of a tube into the bladder to remove urine) included the size of the suprapubic catheter, balloon sizing, and the amount of fluid needed to insert for balloon inflation/securement (the balloon keeps catheter in the bladder) for three out of seven sampled residents (Residents R53, R58, and R316) and failed to ensure catheter bags were covered as required for two of seven sampled residents (Residents R58, and R316). Findings include: Review of the facility policy "Suprapubic Catheter Replacement" dated 1/3/24, indicated verify that there is a physician's order. Review the resident's care plan to assess for any special needs of the resident. Supplies needed indicated catheter of proper size and composition (ordered by the physician).	F 0690		

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F 0690 SS=E	Continued from page 36 Review of the facility policy "Dignity" dated 1/3/24, indicated staff are expected to promote dignity and assist residents; for example: helping the resident to keep urinary catheter bags covered. Review of Resident R53's admission record indicated he was originally admitted 6/12/20. Review of Resident R53's MDS assessment (Minimum Data Set assessment: MDS -a periodic assessment of resident care needs) dated 11/28/24, indicated he had diagnoses that included chronic obstructive pulmonary disease (COPD: a disease characterized by persistent respiratory symptoms involving breathlessness, coughing, and obstructed airflow to the lungs), dementia (a condition characterized by memory loss and progressive or persistent loss of intellectual functioning), and benign prostatitis hyperplasia (age-associated prostate gland enlargement that can cause urination difficulty). The diagnoses were the most recent upon review. Section H (Bladder and Bowel) H0100A indicated an "X" for the use of an indwelling catheter.	F 0690		

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F 0690 SS=E	Continued from page 37 Review of Resident R53's care plans dated 11/11/24, indicated he had suprapubic catheter and to monitor for pain and discomfort. Review of Resident R53's physician orders dated 11/16/24, indicated to provide catheter bag to gravity drainage below level of bladder, irrigate suprapubic catheter, and maintain suprapubic catheter in place. Resident R53's suprapubic catheter order did not indicate sizing of the catheter. Review of Resident R53's physician progress notes, other physician orders, nurse clinical notes, and certified nurse practitioner notes did not include the size of catheter in use. During observations on 1/8/25, at 10:04 a.m. Resident R53 observed being assisted to common area on Renaissance Hall (dementia unit). Resident R53 observed with catheter bag and catheter line in use.	F 0690		

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F 0690 SS=E	Continued from page 38 During an interview completed on 1/8/25, at 2:07 p.m. Registered Nurse (RN) Employee E4 confirmed that the facility failed to indicate the size of the suprapubic catheter in the physician order for Resident R53 as required. Review of the admission record indicated Resident R58 admitted to the facility on 7/2/24. Review of Resident R58's MDS dated 10/9/24, indicated the diagnoses of End Stage Renal Disease (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), obstructive uropathy (a structural or functional hindrance of normal urine flow), and gastric reflux (stomach acid). Section H (Bladder and Bowel) H0100A indicated an "X" for the use of an indwelling catheter. Review of Resident R58's care plan dated 11/4/24, indicated resident is dependent for suprapubic catheter care. Catheter: last changed (specify	F 0690		

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F 0690 SS=E	Continued from page 39 date). Change catheter (Frequency specify size and type). Catheter: The resident has (SPECIFY Size) (SPECIFY Type of Catheter). Position catheter bag and tubing below the level of the bladder and away from entrance room door. Review of Resident R58's physician order dated 11/13/24, indicated apply dignity bag and check placement each shift. Exchange suprapubic catheter monthly for chronic urinary retention. The physician order failed to include the size and type of catheter to be utilized for the exchange. Observation on 1/7/25, at 10:03 a.m. Resident R58 observed in bed with catheter drainage bag facing the door entrance and not covered with a dignity bag as required. Interview on 1/7/25, at 10:05 a.m. Registered Nurse (RN) Employee E8 confirmed Resident R58 was in bed with catheter drainage bag facing the door entrance and not covered with a dignity bag as required.	F 0690		

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F 0690 SS=E	Continued from page 40 Review of the admission record indicated Resident R316 admitted to the facility on 12/4/24. Review of Resident R316's MDS dated 12/11/24, indicated the diagnoses of high blood pressure, Multiple Sclerosis (immune system eats away at protective covering of nerve cells), and Diabetes(a long-term condition in which the body has trouble controlling blood sugar and using it for energy). Review of Resident R316's care plan dated 12/5/24, indicated the resident has suprapubic catheter. Position catheter bag and tubing below the level of the bladder and away from entrance door. The plan of care failed to include the type and size of catheter being utilized. Review of Resident R316's physician orders on 1/9/25, at 9:00 a.m. failed to indicate the size and type of catheter to be utilized. Observation on 1/7/25, at 12:05 p.m. Resident	F 0690		

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F 0690 SS=E	Continued from page 41 R316 observed in bed with catheter drainage bag facing the door entrance and not covered with a dignity bag as required. Interview on 1/7/25, at 12:05 p.m. Registered Nurse (RN) Employee E8 confirmed Resident R316 was in bed with catheter drainage bag facing the door entrance and not covered with a dignity bag as required. Observation on 1/9/25, at 9:30 a.m. Resident R316 observed in bed with catheter drainage bag facing the door entrance and not covered with a dignity bag as required. Interview on 1/10/25, at 3:00 p.m. the Director of Nursing confirmed the facility failed to ensure that the physician order for a urinary catheter included the size of the suprapubic catheter, balloon sizing, and the amount of fluid needed to insert for balloon inflation/securement for four out of seven sampled residents (Residents R53, R58, R316) and failed to ensure catheter bags were covered as required for	F 0690		

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F 0690 SS=E	Continued from page 42 two of seven sampled residents (Residents R58, and R316). 28 Pa. Code: 201.29(j) Resident rights. 28 Pa. Code: 211.5(f) Clinical records 28 Pa. Code: 211.12(c)(d)(1)(3)(5) Nursing services	F 0690		
F 0693 SS=D		F 0693		

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F 0693 SS=D	Continued from page 43 483.25(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	The tube feeding and water flush bag for resident R14 have been dated RNs and LPNs will be educated by the Director of Nursing, In-Service director or designee on the importance of placing the date hung on both the tube feeding and water flush bag. An audit of all residents having a tube feeding will be conducted weekly for three weeks by the Director of Nursing or designee. Then the audit will be conducted biweekly of all residents receiving a tube feeding. Any deficient practice will be immediately corrected. All data will be forwarded to the QAPI committee and the need for additional monitoring will be determined by the committee.	Completion Date: **02/28/2025** Status: **APPROVED** Date: **01/28/2025**

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F 0693 SS=D	Continued from page 44 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 R14). Findings include: Review of facility policy "Enteral Nutrition" dated 1/2/25, indicated adequate nutritional support through enteral nutrition is provided to residents as ordered. The use of enteral nutrition is based on the results of the comprehensive nutritional assessment, and is consistent with current standards of practice, the resident's advance directives, treatment goals and facility policy. Review of Resident R14's clinical record indicated the resident was admitted to the facility on 9/25/24.	F 0693		

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F 0693 SS=D	Continued from page 45 Review of Resident R14's Minimum Data Set (MDS - a periodic assessment of care needs) dated 12/11/24, indicated diagnoses of cerebral infarction (necrotic tissue in the brain resulting loss of blood and oxygen to the brain), dependance on renal dialysis (a blood purifying treatment given when kidney function is not optimum), and aphasia (an acquired communication disorder that impairs a person's ability to process language). MDS Section K0520 indicated a feeding tube present. Review of current physician orders indicated an enteral feed order continuous for feeding is to be down at 1330 (1:30 p.m.) up at 1830 (6:30 p.m.) Nepro @85 ml (milliliters)/hr (per hour) * 19 hours (1615 ml) with 60 ml water flush every 4 hours. During an observation on 1/7/25, at 10:45 a.m., Resident R14's enteral feeding and water flush bag were hanging on a pole at bedside, both undated. During a follow-up observation, and interview on 1/7/25, at 10:55 a.m., Registered Nurse (RN)	F 0693		

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F 0693 SS=D	Continued from page 46 Employee E6 confirmed that Resident R14's enteral feeding and water flush bag were undated as observed, and 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 R14). 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 0698 SS=E		F 0698		

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 0698 SS=E	Continued from page 47 483.25(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	The facility cannot go backward and re-create documentation (i.e. blood pressures) from the past. Therefore, all RNs, and LPNs, will be educated by the Director of Nursing and/or designee on completely completing the dialysis communication log (example: vital signs, medical changes, status of access site including possible thrill and bruit, and nurse sign off) and having a care plan for the access site/fistula. The facility will audit all dialysis communication logs for all residents for completeness by both the facility and the dialysis center. Additionally, the care plans of the dialysis residents will be audited to ensure the access site/fistula is addressed. This will be completed weekly for three weeks and then three random dialysis residents weekly for three weeks. If a deficient practice is noted in the bottom half of the form competed by the dialysis center it will be returned to them for completion. Any deficient practice will be immediately corrected. All data will	Completion Date: **02/28/2025** Status: **APPROVED** Date: **01/28/2025**

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F 0698 SS=E	Continued from page 48	F 0698	be forwarded to the QAPI committee and the need for additional monitoring will be determined by the committee.	

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F 0698 SS=E	Continued from page 49 Based on review of facility policy, clinical record and staff interview it was determined that the facility failed to make certain consistent dialysis communication was maintained for four of five residents (Residents R14, R22, R58, and R314) and failed to maintain an accurate care plan for dialysis access site for two of five (Resident R22, and R314). Findings include: Review of the facility policy "End-Stage Renal Disease, Care of a Resident with" dated 1/3/24, indicated communication between the dialysis provider and facility staff will occur, and staff will be knowledgeable of the care of grafts and fistulas. The resident's comprehensive care plan will reflect the resident's needs related to End Stage Renal Disease and dialysis care. Review of Resident R14's clinical record indicated the resident was admitted to the facility on 9/25/24.	F 0698		

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F 0698 SS=E	Continued from page 50 Review of Resident R14's Minimum Data Set (MDS - a periodic assessment of care needs) dated 12/11/24, indicated diagnoses of cerebral infarction (necrotic tissue in the brain resulting loss of blood and oxygen to the brain), dependance on renal dialysis (a blood purifying treatment given when kidney function is not optimum), and aphasia (an acquired communication disorder that impairs a person's ability to process language). Review of current physician orders on 1/9/25, indicated Resident R14 attends dialysis on Monday, Wednesday, and Friday each week. A review of the clinical record did not include complete communication forms for the month of December 2024. There were nine incomplete communication sheets (Portion Completed by Nursing Home was incomplete) for the following dates: 12/2/24, 12/4/24, 12/6/24, 12/9/24, 12/13/24, 12/18/24, 12/26/24, 12/28/24, and 12/30/24; and there were 4 communication sheets	F 0698		

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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(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 0698 SS=E	Continued from page 51 that were unable to be found for 12/11/24, 12/16/24, 12/20/24, and 12/23/24. During an interview on 1/9/25, at 10:38 a.m., Registered Nurse (RN) Employee E6 confirmed that the above dates did not include completed communication forms as required. Review of the admission record indicated Resident R22 was admitted to the facility on 10/3/23. Review of Resident R22's MDS dated 11/7/24, indicated the diagnoses of renal failure (condition where the kidneys lose the ability to remove waste and balance fluids) with dialysis, stroke (damage to the brain from an interruption of blood supply), and hemiplegia (paralysis of one side of the body). Review of physician order dated 12/22/24, indicated Resident R22 attends dialysis on Monday and Sunday. Review of physician order dated 10/2/24, indicated	F 0698		

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F 0698 SS=E	Continued from page 52 check AV Fistula (arteriovenous a surgical connection between an artery and a vein creating a natural pathway for blood flow) every shift for bruit (heard with a stethoscope) and thrill (a palpated vibration caused by flood flowing through fistula). Notify physician if either is absent. Review of Resident R22's care plan failed to include monitoring of the AV fistula for bruit and thrill. A review of Resident R22's clinical record did not include complete dialysis communication forms. Communications in the book were incomplete dated: 12/30/24 before dialysis blank no date form before dialysis blank 12/23/24 before and after dialysis incomplete 12/26/24 before dialysis incomplete 12/9/24 before and after dialysis incomplete 10/25/24 before dialysis incomplete 10/21/24 before dialysis incomplete 10/18/24 before dialysis incomplete 10/14/24 before dialysis incomplete	F 0698		

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F 0698 SS=E	Continued from page 53 10/11/24 before dialysis incomplete 10/7/24 before dialysis incomplete Interview on 1/7/25, at 2:43 p.m. Registered Nurse (RN) Employee E6 confirmed the dialysis communication forms were incomplete on the 11 forms reviewed. Review of the admission record indicated Resident R58 was admitted to the facility on 7/2/24. Review of Resident R58's MDS dated 10/9/24, indicated the diagnoses of renal insufficiency (condition where the kidneys lose the ability to remove waste and balance fluids), obstructive uropathy (a structural or functional hindrance of normal urine flow), and dependence on dialysis. Review of Resident R58's current physician orders indicated Dialysis Monday, Wednesday, Friday at 5:00 a.m. Check hemodialysis catheter dressing every shift.	F 0698		

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F 0698 SS=E	Continued from page 54 Review of Resident R58's care plan dated 10/24/14 indicated do not take blood pressure in arm with graft. Monitor access site for redness. Review of Resident R58's clinical record did not include complete dialysis communication forms. Communications in the book were incomplete dated: 1/6/25, 1/2/25, 12/30/24, 12/28/24, and 12/23/24. Interview on 1/7/24, at 1:10 p.m. Registered Nurse (RN) Employee E8 confirmed the dialysis communication forms were incomplete on the five forms reviewed. Review of the admission record indicated Resident R314 was admitted to the facility on 1/4/25, with 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 end stage renal disease (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	F 0698		

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F 0698 SS=E	Continued from page 55 maintain life) Review of physician order dated 1/6/25, indicated renal dialysis on Monday, Wednesday, and Friday. Right tunneled dialysis catheter for dialysis. Review of Resident R314's care plan did not include a nursing plan of care for dialysis monitoring of access device or communication with the dialysis center. Simply stated he goes Monday, Wednesday, and Friday to dialysis. Review of Resident R314's clinical record did not include complete dialysis communication forms for 1/6/25. Interview on 1/7/25, at 1:10 p.m. Health Unit Coordinator (HUC) Employee E9 confirmed there was not a sheet from 1/6/25, as he just made the dialysis book today, 1/7/25. Interview on 1/10/25, at 3:00 p.m. the Director of Nursing confirmed the facility failed to make certain	F 0698		

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F 0698 SS=E	Continued from page 56 consistent dialysis communication was maintained for four of five residents (Residents R14, R22, R58, and R314) and failed to maintain an accurate care plan for dialysis access site for two of five (Resident R22, and R314). 28 Pa. Code: 211.5(f) Clinical records 28 Pa. Code: 211.12(c)(d)(1)(3)(5) Nursing services	F 0698		
F 0730 SS=E		F 0730		

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F 0730 SS=E	Continued from page 57 483.35(d)(7) Nurse Aide Peform Review-12 hr/yr In-Service §483.35(d)(7) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g). This REQUIREMENT is not met as evidenced by:	F 0730	The facility will complete annual performance evaluation for all those nurse aide staff employed at the facility for a year. This includes nurse aides E10, E11 and E12. The Administrator will re-educate the Director of Nursing and Human Resources that evaluations are a requirement annually for nurse aide staff. A master list of current nurse aide employees will be viewed weekly for six weeks to determine the who qualifies for this annual performance review. The Director of nursing or designee will complete these evaluations. The evaluation period for all employees will be June 2025.	Completion Date: **02/28/2025** Status: **APPROVED** Date: **01/28/2025**

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F 0730 SS=E	Continued from page 58 Based on review of personnel records and staff interview it was determined that the facility failed to complete annual performance evaluations for three out of four nurse aide personnel records (Nurse Aide (NA) Employee E10, NA Employee E11, and NA Employee E12). Findings include: Review of CFR (Code of Federal Regulations) §483.35(d)(7) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g). Review of NA Employee E10's personnel record indicated she was hired to the facility on 8/25/14. Review of NA Employee E11's personnel record indicated she was hired to the facility on 3/2/09.	F 0730		

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F 0730 SS=E	Continued from page 59 Review of NA Employee E12's personnel record indicated he was hired to the facility on 11/26/18. Review of personnel records did not include an annual performance evaluations based on the date of hire for NA Employee E10, NA Employee E11, and NA Employee E12. Interview on 1/10/25, at 2:21 p.m. the Nursing Home Administrator confirmed that the facility failed to complete annual performance evaluations based on date of hire for NA Employee E10, NA Employee E11, and NA Employee E12. 28 Pa Code: 201.14 (a) Responsibility of licensee 28 Pa Code: 201.18 (b)(1)(3) Management	F 0730		

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F 0730 SS=E	Continued from page 60	F 0730		
F 0849 SS=D		F 0849		

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F 0849 SS=D	Continued from page 61 483.70(n)(1)-(4) Hospice Services §483.70(n) Hospice services. §483.70(n)(1) A long-term care (LTC) facility may do either of the following: (i) Arrange for the provision of hospice services through an agreement with one or more Medicare-certified hospices. (ii) Not arrange for the provision of hospice services at the facility through an agreement with a Medicare-certified hospice and assist the resident in transferring to a facility that will arrange for the provision of hospice services when a resident requests a transfer. §483.70(n)(2) If hospice care is furnished in an LTC facility through an agreement as specified in paragraph (o)(1)(i) of this section with a hospice, the LTC facility must meet the following requirements: (i) Ensure that the hospice services meet professional standards and principles that apply to individuals providing services in the facility, and to the timeliness of the services. (ii) Have a written agreement with the hospice that is signed by an authorized representative of the hospice and an authorized representative of the LTC facility before hospice care is furnished to any resident. The written agreement must set out at least the following: (A) The services the hospice will provide. (B) The hospice's responsibilities for determining the appropriate hospice plan of care as specified in §418.112 (d) of this chapter.	F 0849	The care plan and physician orders for R59 have been updated to include a diagnosis for hospice care, the provider and their contact information. Additionally, the care plan was reviewed/updated to ensure it was comprehensive to include hospice services. Staff including RNs, and LPNs, and Unit Managers as well as providers will receive additional training on the needed components of a hospice orders and the need for comprehensive care plans. Four residents receiving hospice care with a focus on those most recently admitted to hospice will be reviewed weekly for three weeks to ensure they have the proper provider order as well as a comprehensive care plan. Then two residents receiving hospice services will be reviewed weekly for three weeks to ensure complete hospice orders and comprehensive care plans. Any deficient practice will be immediately corrected. All data will	Completion Date: **02/28/2025** Status: **APPROVED** Date: **01/28/2025**

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F 0849 SS=D	Continued from page 62 (C) The services the LTC facility will continue to provide based on each resident's plan of care. (D) A communication process, including how the communication will be documented between the LTC facility and the hospice provider, to ensure that the needs of the resident are addressed and met 24 hours per day. (E) A provision that the LTC facility immediately notifies the hospice about the following: (1) A significant change in the resident's physical, mental, social, or emotional status. (2) Clinical complications that suggest a need to alter the plan of care. (3) A need to transfer the resident from the facility for any condition. (4) The resident's death. (F) A provision stating that the hospice assumes responsibility for determining the appropriate course of hospice care, including the determination to change the level of services provided. (G) An agreement that it is the LTC facility's responsibility to furnish 24-hour room and board care, meet the resident's personal care and nursing needs in coordination with the hospice representative, and ensure that the level of care provided is appropriately based on the individual resident's needs. (H) A delineation of the hospice's responsibilities, including but not limited to, providing medical direction and management of the patient; nursing; counseling (including spiritual, dietary, and bereavement); social work; providing medical supplies, durable medical equipment, and	F 0849	be forwarded to the QAPI committee and the need for additional monitoring will be determined by the committee.	

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F 0849 SS=D	Continued from page 63 drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related conditions; and all other hospice services that are necessary for the care of the resident's terminal illness and related conditions. (I) A provision that when the LTC facility personnel are responsible for the administration of prescribed therapies, including those therapies determined appropriate by the hospice and delineated in the hospice plan of care, the LTC facility personnel may administer the therapies where permitted by State law and as specified by the LTC facility. (J) A provision stating that the LTC facility must report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by hospice personnel, to the hospice administrator immediately when the LTC facility becomes aware of the alleged violation. (K) A delineation of the responsibilities of the hospice and the LTC facility to provide bereavement services to LTC facility staff. §483.70(n)(3) Each LTC facility arranging for the provision of hospice care under a written agreement must designate a member of the facility's interdisciplinary team who is responsible for working with hospice representatives to coordinate care to the resident provided by the LTC facility staff and hospice staff. The interdisciplinary team member must have a clinical background, function within their State scope of practice act, and have the ability to assess the resident or have access to someone that has the skills and	F 0849		

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F 0849 SS=D	Continued from page 64 capabilities to assess the resident. The designated interdisciplinary team member is responsible for the following: (i) Collaborating with hospice representatives and coordinating LTC facility staff participation in the hospice care planning process for those residents receiving these services. (ii) Communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the patient and family. (iii) Ensuring that the LTC facility communicates with the hospice medical director, the patient's attending physician, and other practitioners participating in the provision of care to the patient as needed to coordinate the hospice care with the medical care provided by other physicians. (iv) Obtaining the following information from the hospice: (A) The most recent hospice plan of care specific to each patient. (B) Hospice election form. (C) Physician certification and recertification of the terminal illness specific to each patient. (D) Names and contact information for hospice personnel involved in hospice care of each patient. (E) Instructions on how to access the hospice's 24-hour on-call system. (F) Hospice medication information specific to each patient. (G) Hospice physician and attending physician (if any)	F 0849		

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F 0849 SS=D	Continued from page 65 orders specific to each patient. (v) Ensuring that the LTC facility staff provides orientation in the policies and procedures of the facility, including patient rights, appropriate forms, and record keeping requirements, to hospice staff furnishing care to LTC residents. §483.70(n)(4) Each LTC facility providing hospice care under a written agreement must ensure that each resident's written plan of care includes both the most recent hospice plan of care and a description of the services furnished by the LTC facility to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, as required at §483.24. This REQUIREMENT is not met as evidenced by:	F 0849		

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F 0849 SS=D	Continued from page 66 Based on a review of facility policy, resident clinical records, and staff interview, it was determined the facility failed to ensure the coordination of hospice services with facility services to meet the needs of each resident for end-of-life care for one of three residents (Resident R59). Findings include: Review of the facility policy "Hospice Services" dated 1/2/25, indicated that hospice services are available to residents at the end of life. The facility is responsible for collaborating with hospice representatives and coordinating facility staff participation in the hospice care planning process for residents receiving these services; obtaining the following information from the hospice: - the most recent hospice plan of care - hospice election form - physician certification and recertification of the terminal illness - names and contact information for hospice personnel involved in hospice care	F 0849		

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F 0849 SS=D	Continued from page 67 - instruction on how to access the hospice's 24-hour on-call system Coordinated care plan for residents receiving hospice services will include the most recent hospice plan of care as well as the care and services provided by the facility. The coordinated care plan will be revised and updated as necessary. Review of Resident R59's clinical admission record indicated that she was admitted to the facility 3/11/22, with diagnoses of heart failure, dysphagia (a condition with difficulty swallowing food or liquid), and high blood pressure. Review of Resident R59's MDS assessment (MDS-Minimum Data Set assessment: periodic assessment of resident care needs) dated 11/2/24, indicated diagnoses remain current upon review. Section O-0110 Special treatments indicated an "x" for hospice services. Review of Resident R59's physician order dated 10/7/24, indicated hospice services were to be	F 0849		

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F 0849 SS=D	Continued from page 68 provided as of this date. Further review of Resident R59's current physician orders failed to indicate a diagnosis for hospice care, which hospice provider was providing this service, and this hospice providers contact information. Review of Resident R59's current care plan on 1/10/25, failed to indicate a plan of care for hospice care and services by facility. During an interview on 1/10/25, at 9:00 a.m., Registered Nurse Assessment Coordinator (RNAC) Employee E7 confirmed that the facility failed to provide appropriate physician orders for hospice to contain hospice diagnosis, hospice provider, and contact information, and at 9:05 a.m., RNAC Employee E7 confirmed that the facility failed to provide a comprehensive care plan to address facility care and services for hospice for Resident R59. During an interview on 1/10/25, at 3:10 p.m., the Nursing Home Administrator (NHA) and Director	F 0849		

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F 0849 SS=D	Continued from page 69 of Nursing (DON) confirmed that the facility failed to ensure the coordination of hospice services with facility services to meet the needs of each resident for end-of-life care for one of three residents (Resident R59). 28 Pa Code: 211.12 (d)(3)(5) Nursing services	F 0849		
F 0880 SS=D		F 0880		

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F 0880 SS=D	Continued from page 70 483.80(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	Residents R-22, R315 and R34 have all experienced resolution of their condition and are now not needing any precautions. All nursing staff (RNs, LPNs, CNAs and Unit Managers) will receive additional training on the types and reasons for transmission-based precautions as well as the PPE required from the In-Service Director or designee. Additionally, staff will demonstrate their ability to effectively don and doff a gown. The Director of Nursing, In-Service Director or designee will observe 10 random resident staff encounters weekly for three weeks to ensure proper PPE. This includes donning of gowns. Additionally, 5 random encounters will be observed for three weeks. Any deficient practice will be immediately corrected. All data will be forwarded to the QAPI committee and the need for additional monitoring will be determined by the committee.	Completion Date: **02/28/2025** Status: **APPROVED** Date: **01/28/2025**

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F 0880 SS=D	Continued from page 71 (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 72	F 0880		

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F 0880 SS=D	Continued from page 73 Based on facility policy, clinical record review, observation, and staff interview, it was determined that the facility failed to follow enhanced barrier precautions for two of seven residents (Residents R22, and R315), failed to have proper interventions carried out by staff for one of two positive Covid residents (Resident R34). Findings include: Review of the facility policy "Transmission Based Precautions" dated 1/3/24, 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, such as an indwelling catheter, trach/vent, central line, and feeding tube. Gowns and gloves are to be on and used when providing high contact care with a resident who is in EBP. Review of the facility policy "Covid -19 Identification and Management of Ill Residents"	F 0880		

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F 0880 SS=D	Continued from page 74 dated 1/3/24, indicated newly identified Covid-19 infection in a resident is evaluated as a potential outbreak. Symptomatic residents are restricted to their rooms and cared for by staff with N95 or higher-level respirator, eye protection, gloves, and a gown. They are placed in Transmission-based precautions with contact isolation for 10 days. Review of the admission record indicated Resident R22 was admitted to the facility on 10/3/23. Review of Resident R22's MDS dated 11/7/24, indicated the diagnoses of renal failure (condition where the kidneys lose the ability to remove waste and balance fluids) with dialysis, stroke (damage to the brain from an interruption of blood supply), and hemiplegia (paralysis of one side of the body). Review of physician order dated 12/22/24, indicated Resident R22 attends dialysis on Monday and Sunday. Review of physician order dated 10/2/24, indicated	F 0880		

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F 0880 SS=D	Continued from page 75 check AV Fistula (arteriovenous a surgical connection between an artery and a vein creating a natural pathway for blood flow) every shift for bruit (heard with a stethoscope) and thrill (a palpated vibration caused by flood flowing through fistula). Notify physician if either is absent. The orders failed to include an order for enhanced barrier precautions (EBP) for indwelling medical devices as required. Review of Resident R22's care plan failed to include interventions and management of EBP relating to dialysis access devices as required. Observation on 1/8/25, at 10:09 a.m. Resident R22's door was adorned with EBP signage. Interview on 1/8/25, at 10:09 a.m. Registered Nurse (RN) Employee E14 was asked to show Survey Agency (SA) Resident R33's tunneled catheter and AV fistula site. SA had to stop and instruct RN Employee E14 that a gown and gloves were required for the EBP.	F 0880		

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F 0880 SS=D	Continued from page 76 Observation on 1/8/25, at 10:10 a.m. RN Employee E14 proceeded to don gown. He tied the arms of the gown around his neck leaving his arms and upper body exposed. The built in hole for the head to go through was not utilized. Both arms were not inside the sleeves of the gown. Interview on 1/8/25, at 10:11 a.m. RN Employee E14 indicated he thought these gowns were the "apron type" and admitted he was not familiar with donning these gowns. Review of the admission record indicated Resident R315 was admitted to the facility 12/25/24. Review of Resident R315's MDS dated 12/31/24 indicated the diagnoses of breast cancer with secondary bone cancer, pain, and anxiety. Review of Resident R315's physician orders 1/4/25, indicated Isolation-Contact and Droplet Precautions. In private room due to respiratory symptoms on 1/3/25. Care and services to be	F 0880		

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F 0880 SS=D	Continued from page 77 provided in the resident's room. Review of Resident R315's care plan failed to include interventions and management of isolation-contact and droplet precautions. Observation on 1/8/25, at 9:22 a.m. the sign on Resident R315's door indicated EBP. Nurse Aide (NA) Employee E15 was observed assisting resident out of the bed and transferring her into the bathroom. NA Employee E15 did not have a gown on as required for EBP and did not have a N95 respirator on for Droplet precautions as required by physician orders. Interview on 1/8/25, at 9:30 a.m. RN Employee E8 confirmed the signage was not appropriate for Resident R315 and that the NA Employee was not wearing the appropriate PPE as required. Review of the admission record indicated Resident R34 admitted to the facility on 6/26/19.	F 0880		

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F 0880 SS=D	Continued from page 78 Review of Resident R34's MDS dated 12/15/24, indicated diagnoses of Down's Syndrome (a genetic chromosome 21 disorder causing developmental and intellectual delays), heart failure (heart doesn ' t pump blood as well as it should), and renal insufficiency (condition where the kidneys lose the ability to remove waste and balance fluids). Review of Resident R34's physician orders dated 1/7/24, indicated vital signs every shift for ten days due to covid positive testing. Covid isolation-contact and airborne precautions in private room due to positive for covid on 1/7/25. Care and services to be provided in the residents room until 1/16/25. Review of Resident R34's care plan dated 1/8/25, indicated the resident has covid, airborne contact isolation initiated on 1/7/25. Observation on 1/8/25, at 9:20 a.m. Resident R34's door was wide open, NA Employee E15 was inside the room with a regular surgical mask in place, no	F 0880		

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F 0880 SS=D	Continued from page 79 gloves, no eye protection, no N95, and no gown. Signage on door indicated airborne precautions. Interview on 1/8/25, at 9:30 a.m. RN Employee E8 confirmed the signage on the door only listed airborne, and that NA Employee E15 was not wearing the appropriate PPE as required. Interview on 1/8/25, at 2:00 p.m. the Infection Preventionist Employee E16 confirmed the facility failed to follow enhanced barrier precautions for two of seven residents (Residents R22, and R315), failed to have proper interventions carried out by staff for one of two positive Covid residents (Resident R34). 28 Pa. Code: 211.5(f) Clinical records 28 Pa. Code: 211.12(c)(d)(1)(3)(5) Nursing services	F 0880		

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F 0880 SS=D	Continued from page 80	F 0880		
F 0943 SS=D		F 0943		

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F 0943 SS=D	Continued from page 81 483.95(c)(1)-(3) Abuse, Neglect, and Exploitation Training §483.95(c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on- §483.95(c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12. §483.95(c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property §483.95(c)(3) Dementia management and resident abuse prevention. This REQUIREMENT is not met as evidenced by:	F 0943	Nurse Aide (e-3) completed the educational material on abuse, neglect and exploitation. All new employees will be educated by Human Resources or the In-Service Director or designee during orientation on abuse neglect and exploitation prior to starting their employment in the clinical areas. Human Resources and the In-Service Director were re-educated on the importance of completing all educational material while in orientation and prior to their employment in the clinical areas. The administrator or designee will review all employee training records after orientation but prior to the employee entering the clinical areas to ensure that abuse, neglect and exploitation education is complete. Audits will be conducted for each orientation class for two months. Any deficient practice will be immediately corrected. All data will be forwarded to the QAPI committee and the need for additional monitoring will be determined by the	Completion Date: **02/28/2025** Status: **APPROVED** Date: **01/28/2025**

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F 0943 SS=D	Continued from page 82	F 0943	committee.	

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F 0943 SS=D	Continued from page 83 Based on review of facility policy, employee personnel records, and staff interview, it was determined that the facility failed to provide training on Abuse, Neglect, and Exploitation on the date of orientation for one out of five sampled records (Nurse aide Employee E3). Findings include: The "Safety-01 Abuse, Neglect, Exploitation general policy" dated 5/1/22, last reviewed 1/3/24, indicated that all employees and contracted staff will be educated upon orientation, annually, and as indicated on topics to include resident rights,privacy and confidentiality , and abuse prevention. Staff will be educated on recognizing the signs of abuse, neglect and exploitation. Review of Nurse aide (NA) Employee E3's personnel record indicated she was hired 10/2/24. Review of nurse deployment documents (form	F 0943		

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F 0943 SS=D	Continued from page 84 indicating the name and number of nursing staff working a specific date), indicated that Nurse aide (NA) Employee E3 first worked on the floor starting 10/7/24. After her orientation was completed, Nurse aide (NA) Employee E3 worked on 10/13/24 and continued to work at the facility. Review of Nurse aide (NA) Employee E3's personnel record did not indicate that she was trained on Abuse, Neglect, and Exploitation policies and procedures until 12/6/24, two months after her date of hire. During an interview on 1/10/25, at 1:12 p.m. the Nursing Home Administrator (NHA) confirmed that the facility failed to provide training on Abuse, Neglect, and Exploitation to Nurse aide (NA) Employee E3 on the date of orientation as required. 28 Pa Code: 201.14 (a) Responsibility of licensee.	F 0943		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395146	A. BLDG: __00_____ B. WING: _____	01/10/2025

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F 0943 SS=D	Continued from page 85 28 Pa Code: 201.18 (b)(1) Management. 28 Pa Code: 201.20 (a)(c) Staff development.	F 0943		

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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	The laboratory member of the QAPI committee has been re-educated on attending the QAPI meetings at least quarterly. Email invitations are provided and a zoom option offered. The administrator will note if attendance is by zoom. Laboratory personnel did attend the QAPI meeting on January 16, 2025. 1/28 all personnel sign in for the QAPI meetings including laboratory personnel. This sign in sheet serves to monitor attendance for all required personnel.	Completion Date: **02/28/2025** Status: **APPROVED** Date: **01/28/2025**

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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P 1020	Continued from page 1 Based on staff interview and review of the facility's Infection Control Committee attendance records, the facility failed to ensure that the nine required multidisciplinary members were present at the Infection Control meetings (laboratory personnel) for two of four quarters (Quarters Three and Four of 2024). 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 Attendance Log for Quarters Three and Four of 2024, failed to include laboratory personnel. During an interview on 1/9/25, at 1:01 p.m., Administrative Assistant Employee E13 confirmed that the facility's Infection Control Committee Attendance Log for Quarter four of 2023, failed to include laboratory personnel and pharmacy staff as required.	P 1020		
P 1440		P 1440		

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P 1440	Continued from page 3 Personnel policies and procedures. (1) The employee's job description, educational background and employment history. This REGULATION is not met as evidenced by:	P 1440	The personnel record for registered nurse (E-2) has been updated to include the employee's job description, educational background, employment history and a reference check. Human Resources and the In-service director have been re-educated on the importance of ensuring that all pre-employment documentation including but not limited to the employee's job description, educational background, employment history and a reference check must be obtained prior to the first day of employment. All new hire paperwork including the employee's job description, educational background, employment history and a reference check will be audited every two weeks for two months by the administrator or designee to ensure all documentation is completed prior to their first day of employment. Any deficient practice will be immediately corrected. All data will be forwarded to the QAPI committee and the need for additional	Completion Date: **02/28/2025** Status: **APPROVED** Date: **01/28/2025**

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P 1440	Continued from page 4	P 1440	monitoring will be determined by the committee.	

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P 1440	Continued from page 5 Based on review of facility policy, employees personnel records and staff interview, it was determined that the facility failed to ensure personnel records included a copy of the employee's job description, educational background, employment history and a reference check for four out of five sampled records (Registered Nurse (RN) Employee E2). Findings include: The "Safety-01 Abuse, Neglect, Exploitation general policy" dated 5/1/22, last reviewed 1/3/24, indicated that prior to the employee's first day of employment, the facility will make reasonable efforts to obtain personal and professional reference information. Documentation will note conducted attempts. Review of Registered Nurse (RN) Employee E2's was hired to the facility on 9/3/24. Review of Registered Nurse (RN) Employee E2's	P 1440		

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P 1440	Continued from page 6 personnel record did not include a copy of the employee's job description, educational background, employment history and a reference check. Review of nurse deployment documents (a document indicating the name and number of nursing staff working a specific date), indicated that Registered Nurse (RN) Employee E2 worked 9/17/24 and was no longer on orientation. She continued to work for the facility. During an interview on 1/10/25, at 1:12 p.m. the Nursing Home Administrator (NHA) confirmed that the facility failed to ensure personnel records included a copy of the employee's job description, educational background, employment history and a reference check for Registered Nurse (RN) Employee E2 as required.	P 1440		

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P 1700	Prevention, control and surveillance of tuber (b) Recommendations of the Centers for Disease Control and Prevention (CDC), United States Department of Health and Human Services (HHS) shall be followed in screening, testing and surveillance for TB and in treating and managing persons with confirmed or suspected TB. This REGULATION is not met as evidenced by:	P 1700	Registered Nurse (E-2) has obtained a pre-employment screening test for Tuberculosis. The negative results are noted on the per-employment health questionnaire. Human Resources and the In-service coordinator have been re-educated on the importance of securing a negative pre-employment screening test for Tuberculosis prior to the employees first day at the facility All new hire paperwork including the pre-employment test for Tuberculosis will be audited every two weeks for two months prior to orientation by the administrator or designee to ensure they have a recorded negative pre-employment screening for Tuberculosis. Any deficient practice will be immediately corrected. All data will be forwarded to the QAPI committee and the need for additional monitoring will be determined by the committee.	Completion Date: **02/28/2025** Status: **APPROVED** Date: **01/28/2025**

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P 1700	Continued from page 8 Based on review of facility policy, personnel records, and staff interview, it was determined that the facility failed to implement pre-employment screening procedures for Tuberculosis (TB) for one of five newly hired personnel records (Registered Nurse (RN) Employee E2). Findings include: The facility "Tuberculosis (TB) infection control program"policy reviewed on 1/3/24, indicated that the facility recognizes that Tuberculosis has been identified as a risk in healthcare settings. Screening of residents and employees for latent Tuberculosis infection and active TB as appropriate. Review of Registered Nurse (RN) Employee E2's was hired to the facility on 9/3/24. Review of Registered Nurse (RN) Employee E2's pre-employment health questionnaire dated 8/19/24, indicated that all employees must be tested for TB as a condition of employment. The pre-employment	P 1700		

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P 1700	Continued from page 9 health questionnaire TB section was found unanswered. Review of nurse deployment documents (form indicating the name and number of nursing staff working a specific date), indicated that Registered Nurse (RN) Employee E2 worked and was no longer on orientation on 9/17/24. She continued to work for the facility. Review of Registered Nurse (RN) Employee E2's personnel record and health information did not indicate any TB screening was conducted prior to the date of hire. During an interview on 1/10/25, at 1:12 p.m. the Nursing Home Administrator (NHA) confirmed that the facility failed to implement pre-employment screening procedures for Tuberculosis (TB) for Registered Nurse (RN) Employee E2 as required.	P 1700		

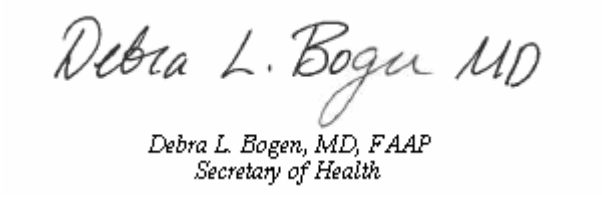
Certified End Page

CANTERBURY PLACE

STATE LICENSE NUMBER: 050702

SURVEY EXIT DATE: 01/10/2025

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



Pennsylvania
Department of Health

THIS IS A CERTIFICATION PAGE

PLEASE DO NOT DETACH

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