STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395361	A. BLDG: 00 B. WING:	06/26/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
PLEASANT RIDGE MANOR- WEST STATE LICENSE NUMBER: **311002**	**8300 WEST RIDGE ROAD** **GIRARD, PA 16417**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0000	INITIAL COMMENT Based on a Medicare/Medicaid Recertification, State Licensure, and Civil Rights Compliance Survey completed on June 26, 2025, it was determined that Pleasant Ridge Manor West was not in compliance with the following requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities and the 28 PA Code, Commonwealth of Pennsylvania Long Term Care Licensure Regulations.	F 0000		
F 0628 SS=D		F 0628		

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 0628 SS=D	Continued from page 1 483.15(c)(2)(iii)(3)-(6)(8)(d)(1)(2); 483.21(c)(2)(i)-(iii) Discharge Process §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i) (A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must-	F 0628	Preparation and/or evaluation of the following Plan of Correction set forth in these documents does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusion set forth in the Statement of Deficiency. The Plan of Correction is prepared and/or executed solely because it is required by the provisions of federal and state law. Registered Nurse's User Defined Assessment/Transfer Assessment was created to ensure that all pertinent information is relayed to the receiving provider. All Registered Nurse Supervisors will be educated on completing this assessment and documenting that Physician/Resident Representative were notified. All licensed staff will be educated on	Completion Date: **07/31/2025** Status: **APPROVED** Date: **07/08/2025**

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F 0628 SS=D	Continued from page 2 (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days.	F 0628	the requirements on the completing the e-interact transfer form, copy of current Medication Administration record and sending the summary of episode note form. All requirements are captured in the e-interact and/or summary of episode note. Director of Nursing/Designee will audit daily any resident transfers to ensure all pertinent information is relayed to the receiving provider. Audit will be completed daily for thirty days and if compliant will audit weekly for thirty days and then change to quarterly. Results of these audits will be reviewed at the Quality Assurance Committee meeting monthly for review until audits meet 100% compliance for three consecutive quarters. The Director of Nursing/designee will be responsible for compliance. Completion Date: 7/31/25	

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F 0628 SS=D	Continued from page 3 §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy	F 0628		

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F 0628 SS=D	Continued from page 4 for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any;	F 0628		

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F 0628 SS=D	Continued from page 5 (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter).	F 0628		

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F 0628 SS=D	Continued from page 6 This REQUIREMENT is not met as evidenced by:	F 0628		

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F 0628 SS=D	Continued from page 7 Based on review of facility policy and clinical records and staff interview it was determined that the facility failed to make certain that the necessary resident information was communicated to the receiving health care provider for one of 35 residents reviewed (Resident R19). Findings include: Review of facility policy entitled "Transfer and Discharge Policy" dated 6/18/25, indicated "When the facility transfers or discharges a resident ... the facility must ensure that the transfer or discharge is documented in the residents medical record and appropriate information is communicated to the receiving health care institution or provider." And "Documentation of the resident's medical record must include: ... Information provided to the receiving provider ..." Review of Resident R19's clinical record revealed an admission date of 12/12/24, with diagnoses that included respiratory failure (a condition where your	F 0628		

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F 0628 SS=D	Continued from page 8 lungs don't exchange air properly), congestive heart failure (the inability of the heart to maintain an adequate supply of blood to organs and tissues), and obstructive sleep apnea (a condition when a person repeatedly stops and starts breathing when they are sleeping). Review of Resident R19's clinical record revealed a progress note dated 5/15/25, at 3:50 p.m. indicating the resident was transfered to the hospital. The clinical record lacked evidence that Resident R19's necessary clinical information was communicated to the receiving health care provider. During an interview on 6/25/25, at 2:35 p.m. the Director of Nursing (DON) confirmed that there was no evidence that the necessary clinical information for Resident R19 was provided to the receiving healthcare provider upon transfer. The DON also confirmed when a resident is transferred the necessary clinical information should be provided to the receiving health care provider and documented in the resident's clinical record.	F 0628		

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F 0628 SS=D	Continued from page 9 28 Pa. Code 201.18(e)(1) Management 28 Pa. Code 201.29(c.3) (2) Resident rights	F 0628		
F 0641 SS=B		F 0641		

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F 0641 SS=B	Continued from page 10 483.20(g)(h)(i)(j) Accuracy of Assessments §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. §483.20(i) Certification. §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed. §483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. §483.20(j) Penalty for Falsification. §483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. §483.20(j)(2) Clinical disagreement does not constitute a material and false statement.	F 0641	Resident R13's Minimum Dataset Assessment dated 4/1/25 was corrected with the removal of weight loss, and resubmitted 7/8/25. Resident R43's Minimum Dataset Assessment dated 8/29/24, 11/21/24, 2/13/24, 5/8/25, and 6/3/25 were corrected to reflect the resident was receiving an antiplatelet and not an anticoagulant on 7/8/25 and resubmitted. The Utilization Review Director provided education to all staff that complete Section N and K of the Minimum Dataset Assessment. The Utilization Review Director or designee will conduct weekly audit of a minimum of 25% of the Comprehensive and Quarterly Minimum Dataset Assessments for accurate documentation of medication classification of antiplatelet vs. anticoagulant. The Utilization Review Director or designee will conduct weekly audit	Completion Date: **07/31/2025** Status: **APPROVED** Date: **07/10/2025**

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F 0641 SS=B	Continued from page 11 This REQUIREMENT is not met as evidenced by:	F 0641	of a minimum of 25% of the comprehensive and Quarterly Minimum Dataset Assessment for accurate documentation of weight loss. All residents most recent Minimum Dataset Assessment will be audited on Section K and N and errors will be corrected and resubmitted. Audits will be forwarded to the Quality Assurance review monthly until 100% compliance for three consecutive months, then quarterly. Completion Date: 7/31/25	

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F 0641 SS=B	Continued from page 12 Based on review of Minimum Data Set (MDS - federally mandated standardized assessment conducted at specific intervals to plan resident care), clinical records and staff interview, it was determined that the facility failed to ensure that the MDS assessment accurately reflected the status for two of 35 residents reviewed (Residents R13 and R43). Findings include: Resident R13's clinical record revealed an admission date of 1/9/25, with diagnoses that included bipolar disorder (condition of mood swings characterized by manic highs and depressive lows), anxiety, and chronic pain. Review of MDS instructions for section K0300 indicated that if weight loss of five percent or more in the last month or loss of 10 percent or more in the last six months to code "yes." During an interview on 6/26/25, at 8:55 a.m. the	F 0641		

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F 0641 SS=B	Continued from page 13 Registered Dietitian confirmed that R13 did not have significant weight loss and the MDS dated 4/1/25, for section Swallowing/Nutritional Status Section K0300 Weight Loss: Loss of 5% or more in the last month or loss of 10% or more in the last 6 months was coded incorrectly. Resident R43's clinical record revealed an initial admission date of 6/07/24, with diagnoses that included Type 2 diabetes (chronic condition where the body either doesn't produce enough insulin or can't properly use the insulin it produces, leading to high blood sugar levels), bipolar disorder (mental health condition causes extreme mood swings that include emotional highs, called mania, and lows, known as depression), long-term kidney disease, and adult failuer to thrive (syndrome of decline in older adults characterized by weight loss, decreased appetite, poor nutrition, and inactivity). Resident R43's clinical record revealed a physician's order originally dated 6/08/24, and reordered 5/28/25, to administer ticagrelor oral tablet	F 0641		

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F 0641 SS=B	Continued from page 14 (anti-platelet-prevents platelets in your blood from sticking together to prevent blood clots) three times a day. Review of MDS instructions for Section N0415 indicated to check if the resident is taking any of the listed medications by pharmacologial classification. Resident R43's Quarterly MDS dated 8/29/24, Quarterly MDS dated 11/21/24, Quarterly MDS dated 2/13/25, Annual MDS dated 5/08/25, and Quarterly MDS dated 6/03/25, Sections N0415 indicated that Resident R43 was receiving an anticoagulant. During an interview on 6/25/25, at 2:56 p.m. Registered Nurse Assessment Coordinator Employee E4 confirmed that Resident R43's Quarterly MDS dated 8/29/24, Quarterly MDS dated 11/21/24, Quarterly MDS dated 2/13/25, Annual MDS dated 5/08/25, and Quarterly MDS dated 6/03/25, Sections N0415 were coded incorrectly for receiving an anticoagulant.	F 0641		

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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 0641 SS=B	Continued from page 15 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 211.5(f)(ix) Medical Records 28 Pa. Code 211.12(d)(3) Nursing services	F 0641		
F 0684 SS=D		F 0684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395361	A. BLDG: 00 B. WING:	06/26/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
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F 0684 SS=D	Continued from page 16 483.25 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	R197's sleeve/glove were placed on resident upon notification. Initial audit was completed for residents with geri sleeve or edema glove orders. All were available and being worn per physician orders. Geri sleeves/edema gloves documented by the nursing assistant in Point Click Care point of care. Geri sleeves/edema gloves will be added to the Licensed Practical Nurse treatment administration record to ensure they are being worn per physician order. All nursing staff will be educated on following the physician orders. Certified Nursing Assistant will be educated on importance of applying geri sleeves/edema gloves as ordered. Ward clerks will be educated on adding these orders to the Licensed	Completion Date: **07/31/2025** Status: **APPROVED** Date: **07/08/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0684 SS=D	Continued from page 17	F 0684	Practical Nurse treatment administration record. All Licensed Practical Nurses will be educated on ensuring residents with orders for sleeves/gloves are wearing as ordered and documenting in the treatment administration record. A daily audit will be conducted by the Registered Nurse Supervisor on each shift to ensure all geri sleeves/edema gloves are on per orders and documented in the resident record. Results of these audits will be reviewed at the Quality Assurance Committee monthly for review until audits meet 100% compliance for three consecutive quarters. The Director of Nursing/designee will be responsible for compliance. Completion Date: 7/31/25	

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F 0684 SS=D	Continued from page 18 Based on review of clinical records, observations, and staff interview, it was determined that the facility failed to ensure that physician's orders were followed for one of 35 residents reviewed (Resident R197). Findings include: Review of Resident R197's clinical record revealed an admission date of 12/11/24, with diagnoses that included hemiplegia (a condition where a person is paralyzed and unable to move one side of their body), hyperlipidemia (high cholesterol), and hypertension (high blood pressure). Review of Resident R197's clinical record revealed a physician's order dated 1/30/25, to apply edema glove (a compression glove to reduce swelling) to left hand. Review of tasks (area in the clinical record where nursing assistants document) revealed a task to apply Geri sleeve (special sleeve worn to protect the skin from injury) to left upper extremity on in the a.m. and off at hour of sleep (HS).	F 0684		

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F 0684 SS=D	Continued from page 19 Observations on 6/23/25, at 3:22 p.m. revealed Resident R197 sitting in his/her wheelchair in their room with no glove/sleeve on their left hand/arm. Observation on 6/24/25, at 9:18 a.m. revealed Resident R197 was lying in their bed with no glove/sleeve on their left hand/arm. Observation again on 6/24/25, at 12:40 p.m. revealed the resident was sitting in their wheelchair with no glove/sleeve on their left hand/arm. Observations on 6/25/25 at 9:00 a.m., 1:30 p.m., and again at 1:40 p.m. revealed the resident sitting in their wheelchair with no glove/sleeve on their left hand/arm. During an interview on 6/25/25, at 1:40 p.m. Licensed Practical Nurse (LPN) Employee E5 confirmed that Resident R197 did not have a glove/sleeve on his/her left hand/arm. LPN Employee E5 also confirmed that Resident R197 should have a glove/sleeve to their hand/arm according to physician's orders.	F 0684		

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F 0684 SS=D	Continued from page 20 28 Pa. Code 211.12(d)(3)(5) Nursing services	F 0684		
F 0688 SS=D		F 0688		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0688 SS=D	Continued from page 21 483.25(c)(1)-(3) Increase/Prevent Decrease in ROM/Mobility §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by:	F 0688	Therapy replaced bilateral missing hand splints of R120 on 6/26/25. Therapy will do an initial audit of all residents with orders for splints to ensure all are available for use. Nursing staff will be educated on informing therapy immediately if resident splints are missing or unavailable. Director of Therapy will continue to educate all nursing staff/therapy staff on applying resident splints per physician orders/splinting schedule. Director of Nursing/ designee will educate all nursing staff on informing therapy immediately if resident splints are missing, damaged or unavailable. Director of Therapy/ designee will conduct a weekly audit that all splints are available to residents. Unit Licensed Practical Nurse will conduct a daily audit to ensure all splints are being worn per the resident schedule. Daily audits will	Completion Date: **07/31/2025** Status: **APPROVED** Date: **07/10/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0688 SS=D	Continued from page 22	F 0688	continue for four weeks, then weekly for four weeks, then monthly for four months, then quarterly. Results of these audits will be reviewed at the Quality Assurance Committee monthly for review until audits meet 100% compliance for three consecutive quarters. The Director of Nursing/designee will be responsible for compliance. Completion Date: 7/31/25	

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F 0688 SS=D	Continued from page 23 Based on review of facility policy and clinical record, observations, and staff interview, it was determined that the facility failed to ensure that resident with limited range of motion received physician ordered treatment and services to prevent further decrease in range of motion for one of four residents reviewed (Resident R120). Findings include: Review of policy entitled "Restorative Nursing: Splints and Orthotics" dated 6/18/25, indicated upon receipt of a physician's order the occupational/physical therapist will issue a splinting device for the resident and nursing staff will follow recommendations/physician's orders and instructions. Review of Resident R120's clinical record revealed an admission date of 3/2/21, with diagnoses that included dementia (a disease that affects short term memory and the ability to think logically), contracture of muscle (a condition that affects a	F 0688		

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F 0688 SS=D	Continued from page 24 muscle to fully stretch or relax causing the muscle to become stiff and unable to bend), and hypothyroidism (a condition when the thyroid produces low amounts of thyroid hormones). Review of Resident R120's clinical record revealed a physician's order dated 10/22/24, for bilateral resting hand splints per standard wear schedule off at breakfast, on at 1:00 p.m., off at supper, on at hour of sleep, off at 2:00 a.m., on at 4:00 a.m. Review of Resident R120's tasks (an area in the clinical record where the nursing assistants document) revealed that documentation lacked evidence that the bilateral resting hand splints were applied per physician's orders. Observations on 6/24/25, at 1:40 p.m. revealed Resident R120 was sitting in his/her wheelchair with no resting hand splints on their bilateral hands. Observation on 6/25/25, at 1:00 p.m. and again at 1:45 p.m. revealed Resident R120 lying in his/her bed with no resting hand splints on their bilateral	F 0688		

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F 0688 SS=D	Continued from page 25 hands. During an interview on 6/25/25, at 1:45 p.m. Licensed Practical Nurse (LPN) Employee E5 confirmed that Resident R120 did not have resting hand splints on his/her bilateral hands. LPN Employee E5 also confirmed that Resident R120 should have his/her resting hand splints on their bilateral hands per physician's orders. 28 Pa. Code 201.18 (b)(1) Management 28 Pa. Code 211.10 (d) Resident care policies 28 Pa. Code 211.12 (d)(1)(3)(5) Nursing services	F 0688		
F 0695 SS=E		F 0695		

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F 0695 SS=E	Continued from page 26 483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by:	F 0695	R32's nebulizer mask was immediately replaced by the Registered Nurse Supervisor upon notification. An initial audit was conducted to determine that all residents with orders for nebulizer had a clean and dated mask or T-pipe. All licensed nursing staff will be educated by the Director of Nursing/Designee on proper cleaning, storing, and dating of nebulizer supplies. A weekly audit will be conducted by the third shift Licensed Practical Nurse to ensure nebulizer supplies remain clean, are dated, and stored properly. Weekly audits by the third shift Licensed Practical Nurse will continue for four weeks, then monthly for four months, then quarterly.	Completion Date: **07/31/2025** Status: **APPROVED** Date: **07/10/2025**

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F 0695 SS=E	Continued from page 27	F 0695	Results of these audits will be reviewed at the Quality Assurance Committee monthly for review until audits meet 100% compliance for three consecutive quarters. The Director of Nursing/designee will be responsible for compliance. Completion Date: 7/31/25. R153's oxygen order was changed to reflect rate, route, and diagnosis. Orders involving titration of oxygen now have supplemental documentation requirements of rate and oxygen saturation level. R195's oxygen order was changed to reflect rate, route, and diagnosis. Standing admission order for "oxygen per oximetry prn/as needed" order was removed from the admission order sets. Oxygen can be applied as a nursing measure. Once prn oxygen is initiated, the Registered Nurse will obtain a	

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F 0695 SS=E	Continued from page 28	F 0695	physician order to reflect the flow rate, route, and rationale for use. The Assistant Director of Nursing did an initial audit was conducted to ensure as needed oxygen orders contained a rate, route and rationale for oxygen use in the physician order. Director of Nursing and Assistant Director of Nursing conducted an audit of all routine oxygen orders today to ensure they contain rate, route, and diagnosis. All nursing staff will be educated by the Director of Nursing/designee on documenting oxygen saturation and flow rate in the resident record for as needed oxygen orders involving titration orders. Ward Clerks will be educated by the Director of Nursing/Designee on adding supplementary documentation of saturation and liter flow to the electronic medication administration record system for as needed oxygen orders involving titration of oxygen.	

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F 0695 SS=E	Continued from page 29	F 0695	Registered Nurses will be educated by the Director of Nursing/ Designee on ensuring that all as needed oxygen orders contain rate of flow, route of administration, and indications for use. Registered Nurse Supervisor will run a weekly report of physician orders to ensure rate, route, rationale are captured in orders for oxygen. Weekly audits will continue for four weeks, then monthly for four months, then quarterly. Results of these audits will be reviewed at the Quality Assurance Committee monthly for review until audits meet 100% compliance for three consecutive quarters. The Director of Nursing/designee will be responsible for compliance. Completion Date: 7/31/25	

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F 0695 SS=E	Continued from page 30 Based on review of facility policies and clinical records, observations, and staff interview, it was determined that the facility failed to provide oxygen and maintain oxygen equipment according to physician's orders for three of five residents reviewed for respiratory services (Residents R32, R153, and R195). Findings include: Review of facility policy entitled "Oxygen Administration" dated 6/18/25, revealed to verify that there is a physician's order for this procedure. Review the physician's order ... for oxygen administration. and turn on oxygen. Unless otherwise ordered, start the flow of oxygen at ... and adjust the oxygen delivery device so that it is comfortable for the resident and the proper flow of oxygen is being administered. Review of facility policy entitled "Oxygen Saturation Pulse Oximetry (SPO2) Oximetry protocol" dated 6/18/25, revealed to verify/obtain a physician's	F 0695		

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F 0695 SS=E	Continued from page 31 order; unless otherwise determined and prescribed by the physician, utilize 90% SPO2 as acceptable; increase or decrease oxygen liter flow by one liter per minute or more. Review of facility policy entitled "Cleaning Nebulizer Cone and Mask or Mouth Piece" dated 6/18/25, revealed that the resident will be provided with new nebulizer supplies every seven days; and rinse nebulizer T-set (T-shaped connection between the mouthpiece or mask to the nebulizer chamber to facilitate delivery of aerosolized medication) nightly with wamr water and leave to dry on a clean paper towel. Review of facility policy entitled "Medication Orders" dated 6/18/25, revealed that oxygen orders must specify the rate of flow, route, and rationale. Resident R32's clinical record revealed an initial admission date of 7/28/22, with diagnoses that included Alzheimer's disease (progressive brain disorder that gradually destroys memory, thinking	F 0695		

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F 0695 SS=E	Continued from page 32 skills, and the ability to carry out even simple tasks), functional quadriplegia (complete inability to move due to severe disability or frailty, not caused by a spinal cord injury or brain damage), and adult failure to thrive (syndrome of decline in older adults characterized by weight loss, decreased appetite, poor nutrition, and inactivity). Resident R32's clinical record revealed a physician's order dated 5/20/25, for Ipratropium-Albuterol Solution (bronchodilators that relax muscles in the airways and increase air flow to the lungs) inhaled through a nebulizer mask four times a day. Review of Resident R32's Medication Administration Record (MAR) revealed that he/she routinely received the nebulized medications four times a day. There no evidence in the Treatment Administration Record (TAR) of cleaning/maintaining nebulizer equipment. Observations on 6/23/25, at 2:05 p.m., 6/24/25, at 11:46 a.m., and 6/25/25, at 11:06 a.m., revealed a	F 0695		

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	395361	A. BLDG: 00 B. WING:	06/26/2025

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F 0695 SS=E	Continued from page 33 nebulizer mask laying directly on Resident R32's nightstand and that the inside portion of the mask contained dried secretions, and an unidentifiable solid matter. During an interview on 6/26/25, at 1:10 p.m. Registered Nurse Employee E2 confirmed that the nebulizer mask was soiled, and there was no evidence of when the mask was changed or cleaned. Review of Resident R153's clinical record revealed an initial admission date of 1/06/23, with diagnoses that included prostate cancer, Type 2 diabetes (chronic condition where the body either doesn't produce enough insulin or can't properly use the insulin it produces, leading to high blood sugar levels), altered mental status, and dementia. The clinical record lacked evidence of a physician's order to provide supplemental oxygen (O2). A departmental progress note dated 6/23/25, at	F 0695		

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F 0695 SS=E	Continued from page 34 11:50 a.m. revealed that Resident R153 experienced a potential seizure, and that O2 was initiated at two liters per minute and his/her oxygen saturation was recorded at 99%. Review of Resident R153's MAR/TAR and departmental progress notes dated 6/23/25, to 6/25/25, lacked evidence of documentation of his/her continued use of O2, the liter flow, or route. Observations on 6/23/25, at 3:48 pm., and 6/24/25, at approximately 10:10 a.m. revealed that Resident R153 was observed in bed with O2 in use at two liters per minute. During an interview on 6/25/25, at 1:30 p.m. Registered Nurse Employee E2 and Licensed Practical Nurse Employee E3 confirmed Resident R153's clinical record contained incomplete orders and parameters for the use of O2, and lacked documentation of continued use of O2, route and liter flow.	F 0695		

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F 0695 SS=E	Continued from page 35 Review of Resident R195's clinical record revealed an admission date of 2/18/25, with diagnoses that included Parkinson's (a chronic and progressive movement disorder that causes shaking, slows a person's ability to move and worsens over time), dementia (a disease that affects short term memory and the ability to think logically), and heart failure (the inability of the heart to maintain an adequate supply of blood to organs and tissues). Review of Resident R195's physician's orders revealed an order for oxygen via nasal cannula (a thin tube with two prongs that fit into the resident's nostrils to deliver oxygen) for comfort only, do not titrate SATS (blood oxygen saturation levels) dated 2/21/25, and another order for oxygen per oximetry (a device that provides an oxygen level by placing it on a person's finger) PRN (as needed) dated 2/18/25. The oxygen orders lacked a flow rate (the amount of oxygen to be delivered). During an interview on 6/26/25, at 10:10 a.m. the Director of Nursing (DON) confirmed that Resident	F 0695		

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F 0695 SS=E	Continued from page 36 R19's oxygen orders lacked a flow rate. The DON also confirmed that Resident R19's oxygen orders were incomplete, and all oxygen orders should indicate a flow rate. 28 Pa. Code 211.10(c) Resident care policies 28 Pa. Code 211.12(d)(1)(5) Nursing services	F 0695		
F 0761 SS=D		F 0761		

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F 0761 SS=D	Continued from page 37 483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by:	F 0761	Refrigerator on Unit H was secured with a lock on the red narcotic box inside the refrigerator. Pharmacy conducted an audit of all medication refrigerators to ensure all had a double locking system. Unit Licensed Practical Nurse will conduct daily audits to ensure narcotic medications are double locked. Audits will continue for four weeks, then weekly for four weeks, then monthly for four months, then quarterly. All licensed nursing staff will be educated by the Director of Nursing/ Designee on the need for double locks of narcotic medications. Results of these audits will be reviewed at the Quality Assurance Committee monthly for review until audits meet 100% compliance for three consecutive quarters. The Director of Nursing/designee will be responsible for compliance.	Completion Date: **07/31/2025** Status: **APPROVED** Date: **07/10/2025**

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F 0761 SS=D	Continued from page 38	F 0761	Completion Date: 7/31/25. Expired medication on Unit A was discarded by the pharmacy on 6/23/25 when notified. Pharmacy has conducted audits of all carts, refrigerators, and all medication rooms and carts to check for all residents expired medications. Licensed nursing staff and pharmacy employees will receive education on proper disposal process of expired medications. 11-7pm Registered Nurse Supervisor will conduct a nightly audit of discontinued or completed medication to be disposed of by the pharmacy. Daily audits will continue for four weeks, then weekly for four weeks, then monthly for four months, then quarterly. Pharmacy will continue to conduct a monthly audit of all medication carts	

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F 0761 SS=D	Continued from page 39	F 0761	and medication rooms expired or discontinued medications. Results of these audits will be reviewed at the Quality Assurance Committee monthly for review until audits meet 100% compliance for three consecutive quarters. The Director of Nursing/designee will be responsible for compliance. Completion Date: 7/31/25.	

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F 0761 SS=D	Continued from page 40 Based on review of facility policies, observations, and staff interviews, it was determined that the facility failed to ensure that medications subject to abuse were stored in separately locked, permanently affixed compartment in one of three medication refrigerators (H Unit), and failed to ensure that medications were discarded in a timely manner for one of three medication rooms observed (A Unit). Findings include: A facility policy entitled "Storage of Medications on Nursing Unit" dated 6/18/25, revealed that controlled substances that require refrigeration will be secured in the red box designated for controlled substances and secured with a pull tight seal or lock. A facility policy entitled "Return of Medication to the Pharmacy" dated 6/18/25, revealed that all of the discontinued medication (except controlled substances) will be sent to the pharmacy for credit and/or disposal.	F 0761		

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F 0761 SS=D	Continued from page 41 Observation on 6/23/25, at 2:15 p.m. of the H Unit medication storage refrigerator revealed Ativan (anti-anxiety, controlled medication) injection syringes, in the red plastic box designated for controlled medications and the box lacked a lock/device to secure the contents. During an interview at the time of the observation, Licensed Practical Nurse (LPN) Employee E1 confirmed the controlled medication box was not secure. During an interview on 6/23/25, at 2:29 p.m. the Director of Nursing (DON) confirmed the red controlled medication box should have a lock/secure device. Observation on 6/23/25, at 3:05 p.m. of the A Unit medication storage refrigerator revealed 1 ½ - 100 milliliter (mL) multi-dose bottles of Cefpodoxime (antibiotic) and one 100 mL bag of Meropenem (antibiotic) intravenous (IV) solution labeled as filled	F 0761		

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F 0761 SS=D	Continued from page 42 on 6/16/25, and with instructions to discard after 6/21/25. During an interview at that time, LPN Employee E6 confirmed that the bottles and IV bag of antibiotics were expired and should have been discarded/returned to pharmacy. During an interview on 6/23/25, at 3:56 p.m. the DON confirmed that the expired medications should have been discarded or returned to the pharmacy. 28 Pa. Code 211.9(a)(1) Pharmacy services 28 Pa. Code 211.12(d)(1)(5) Nursing Services 28 Pa. Code 201.18(b)(1) Management	F 0761		

Certified End Page

PLEASANT RIDGE MANOR- WEST

STATE LICENSE NUMBER: 311002

SURVEY EXIT DATE: 06/26/2025

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

Jeanne Parisi
Deputy Secretary for Quality Assurance

Debra L. Bogen, MD, FAAP
Secretary of Health

Pennsylvania
Department of Health

THIS IS A CERTIFICATION PAGE

PLEASE DO NOT DETACH

THIS PAGE IS NOW PART OF THIS SURVEY