

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395391	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 06/26/2025
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NAME OF PROVIDER OR SUPPLIER: ASBURY HEALTH CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE: 700 BOWER HILL ROAD PITTSBURGH, PA 15243
STATE LICENSE NUMBER: 132602	

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F 0000	INITIAL COMMENT	F 0000		
F 0609 SS=D	Based on a Medicare/Medicaid Recertification, State Licensure, and Civil Rights Compliance survey completed on June 26, 2025, it was determined that Asbury Health Center was not in compliance with the following requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care and the 28 Pa. Code, Commonwealth of Pennsylvania Long Term Care Licensure Regulations as they relate to the Health portion of the survey.	F 0609		

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 0609 SS=D	Continued from page 1 483.12(b)(5)(i)(A)(B)(c)(1)(4) Reporting of Alleged Violations §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §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 0609	R325 was interviewed by management immediately after discovering this nurse's note. Resident recalled the comment and stated she didn't like the aide taking her to the bathroom in a wheelchair as she preferred the walker. A grievance form was completed for not following resident preference and resolved to the resident's satisfaction. Allegation of abuse was reported upon receipt of survey results. A review of last 30 days of grievances was conducted to ensure no other grievance was reported as an allegation of abuse that should have been, no negative findings. DON and unit managers will be educated by the NHA to review the 24-hour progress note report daily for any notes triggering an allegation of abuse and report accordingly. NHA or designee will audit 24-hour progress notes for the same weekly x 4 weeks, then monthly x 2 months. Results will be reviewed at QAPI and revised as needed.	Completion Date: 08/03/2025 Status: APPROVED Date: 07/14/2025

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F 0609 SS=D	Continued from page 2 Based on review of facility policy, clinical records, facility documents, and staff interviews, it was determined that the facility failed to report an allegation of neglect to the State Agency for one of four residents (Resident R325). Finding include: Review of facility policy "Abuse, Neglect, Exploitation and Misappropriation Prevention Program" dated 3/26/25, indicated residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual, or physical abuse, and physical or chemical restraints not required to treat the resident's symptoms. Review of the facility policy "Abuse, Neglect, Exploitation or Misappropriation-Reporting and Investigating" dated 3/26/25, indicated if resident abuse, neglect, exploitation, misappropriation of	F 0609		

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F 0609 SS=D	Continued from page 3 resident property or injury of unknown source is suspected, the suspicion must be reported immediately to the administrator and to other officials according to state law. The administrator or the individual making the allegation immediately reports his or her suspicion to the following persons or agencies: state licensing/certification agency responsible for surveying/licensing the facility; local/state ombudsman, resident's representative, adult protective services, law enforcement officials, resident's attending physician and the facility medical director. Review of Resident R325's admission record indicated the resident was admitted on 6/6/25 , with diagnoses that included high blood pressure, diabetes (blood sugar too high or too low), muscle weakness and cognitive communication deficit (difficulties in communication due to impairments in cognitive processes like attention, memory, and problem-solving, rather than primary speech or language disorders).	F 0609		

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F 0609 SS=D	Continued from page 4 Review of Resident R325's Minimum Data Set (MDS- a periodic assessment of care needs) dated 6/13/25, indicated the diagnoses remained current. Review of Resident R325's progress note dated 6/15/25. indicated that Registered Nurse (RN) Employee E8 came to RN Employee E9 stating that the resident wanted to speak with the supervisor on duty. Upon entering the resident's room, resident was sitting in the wheelchair watching TV. When asked, how may I help you, resident stated that the certified nursing aide (CNA) Employee E10 was "abusing an old lady". This RN Employee E8 asked resident to explain what had happened, the resident explained that the CNA Employee E10 told her to use the wheelchair to go to the bathroom instead of walking, which the resident didn't want to do, then the CNA Employee E10 "pushed my chair hard and on purpose". Resident stated she wanted "something done about this immediately and in writing". Resident R325 requested for this CNA Employee E10 not to be assigned to her or come in her room	F 0609		

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F 0609 SS=D	Continued from page 5 again. Director of Nursing (DON) and Nursing Home Administrator (NHA) were made aware of situation. RN Employee E8 was made aware that going forward there will have to be two aides going into her room to provide care. Review of documentation provided to the State Agency from 6/1/25, to 6/22/25, did not include Resident R325's incident of abuse. During an interview on 6/24/25, at 2:50 p.m. the Director of Nursing confirmed the facility failed to report an allegation of abuse to the State Agency for one of four residents (Resident R325). 28 Pa. Code:201.14(a) Responsibility of licensee. 28 Pa. Code:201.18(e)(1) Management. 28 Pa. Code:207.2(a) Administrator's responsibility. 28 Pa. Code: 211.10(d) Resident care policies.	F 0609		

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F 0641 SS=D	<p>483.20(g)(h)(i)(j) Accuracy of Assessments</p> <p>§483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status.</p> <p>§483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.</p> <p>§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.</p> <p>§483.20(j) Penalty for Falsification. §483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly-</p> <p>(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</p> <p>(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.</p> <p>§483.20(j)(2) Clinical disagreement does not constitute a</p>	F 0641	<p>R71's MDS assessments were modified to reflect hospice care. MDS assessments for all residents on hospice were reviewed to ensure they indicated the residents were receiving hospice care. No other inaccuracies noted.</p> <p>NHA or designee will educate the MDS department on routine auditing of residents on hospice to ensure it is captured in their assessments. MDS Coordinator or designee will audit resident assessments for hospice care weekly x 4 weeks, then monthly x 2 months. Results will be reviewed at QAPI and revised as needed.</p>	<p>Completion Date: 08/03/2025 Status: APPROVED Date: 07/11/2025</p>

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F 0641 SS=D	Continued from page 7 material and false statement. This REQUIREMENT is not met as evidenced by:	F 0641		

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F 0641 SS=D	Continued from page 8 Based on review of facility clinical records, observations and staff interview, it was determined that the facility failed to make certain that resident assessments were accurate for one of five residents (Resident R71). Findings include: Review of facility policy "Resident Assessments" reviewed 4/1/24 and 3/26/25, indicated a comprehensive assessment of every resident 's needs is made at intervals designated by OBRA and PPS requirements. A "comprehensive assessment" includes completion of the Minimum Data Set (MDS - a mandated assessment of a resident's abilities and care needs), completion of the care area assessment (CAA) process, and development of the comprehensive care plan. Review of the clinical record indicated that Resident R71 was re-admitted to the facility on 2/27/24, with diagnoses that included diabetes, dementia (group of symptoms affecting memory, thinking and social	F 0641		

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F 0641 SS=D	Continued from page 9 abilities), and repeated falls. Review of a physician order dated 7/12/24, indicated Resident R71 was admitted to hospice services. Review of the MDS dated 3/16/25, indicated the diagnoses remain current. Further review of the MDS dated 12/14/24, Section O: Special Treatments, Procedures, and Programs, O0110 K1 Hospice Care failed to indicate Resident R71 was receiving hospice care at the facility. Review of the MDS dated 3/16/25, Section O: Special Treatments, Procedures, and Programs, O0110 K1 Hospice Care indicated Resident R71 was not receiving hospice care at the facility. During an interview on 2/14/25, at 12:05 p.m. the Registered Nurse Assessment Coordinator (RNAC) Employee E7 confirmed the facility failed to complete an accurate assessment for Resident R58.	F 0641		

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F 0656 SS=D	<p>483.21(b)(1)(3) Develop/Implement Comprehensive Care Plan</p> <p>§483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -</p> <p>(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and</p> <p>(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).</p> <p>(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.</p> <p>(iv) In consultation with the resident and the resident's representative(s)-</p> <p>(A) The resident's goals for admission and desired outcomes.</p> <p>(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate</p>	F 0656	<p>R57 care plan was updated to reflect the diagnosis of dementia with appropriate interventions.</p> <p>All residents with dementia were audited to ensure it was reflected appropriately in their care plans.</p> <p>NHA or designee will educate the RNAC department on the need for dementia diagnosis to be care planned and reviewed with each MDS assessment to ensure care plans are person centered.</p> <p>RNAC or designee will audit care plans for dementia diagnoses weekly x 4 weeks, then monthly x 2 months. Results will be reviewed at QAPI and revised as needed.</p>	<p>Completion Date: 08/03/2025</p> <p>Status: APPROVED</p> <p>Date: 07/11/2025</p>

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F 0656 SS=D	Continued from page 11 entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by:	F 0656		

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F 0656 SS=D	<p>Continued from page 12</p> <p>Based on a review of facility policy, clinical records, and staff interview, it was determined that the facility failed to develop care plans that included instructions to provide person centered care for one of three residents (Resident R57).</p> <p>Findings include:</p> <p>Review of facility's policy "Care Plans, Comprehensive Person-Centered" dated 3/26/25, indicated the facility will develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>Review of the clinical record face sheet revealed that Resident R57 was admitted to the facility on 12/12/19, with a diagnosis of dementia.</p> <p>Review of the comprehensive Minimum Data Set (MDS - periodic assessment of resident care needs) dated 11/14/24, indicated Resident R57 had a</p>	F 0656		

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F 0656 SS=D	Continued from page 13 diagnosis of dementia. Review of Resident R57's care plan dated 5/22/25, failed to reveal a care plan with goals and interventions for dementia. During an interview on 6/26/25, at 12:30 p.m. the Director of Nursing confirmed that the facility failed to ensure that a comprehensive resident care plan was complete for resident care needs for Resident R57. 28 Pa. Code 211.12(d)(5) Nursing Services.	F 0656		
F 0684 SS=D		F 0684		

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F 0684 SS=D	Continued from page 14 483.25 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	Residents R58, R64, and R111 doctor's were notified of blood sugars out of parameters. A one week of 24 hour reports were reviewed for physician notification needs. DON or designee will educate nurses on need to notify MD for all blood sugars out of range per order. DON or designee will audit five diabetic residents for blood sugar MD notification weekly x 4 weeks, then monthly x 2 months. Results will be reviewed at QAPI and revised as needed.	Completion Date: 08/03/2025 Status: APPROVED Date: 07/11/2025

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F 0684 SS=D	Continued from page 15 Based on review of facility policy, clinical records, and staff interviews, it was determined that the facility failed to assess, document, and notify physicians of increased and decreased Capillary Blood Glucose (CBG) levels for three of nine residents reviewed (Residents R58, R64, and R111). Findings include: The Centers for Disease Control defines diabetes as: Diabetes Mellitus is a chronic (long-lasting) health condition that affects how your body turns food into energy. Most of the food you eat is broken down into sugar (also called glucose) and released into your bloodstream. When your blood sugar goes up, it signals your pancreas to release insulin. Insulin acts like a key to let the blood sugar into your body's cells for use as energy. If you have diabetes, your body either doesn't make enough insulin or can't use the insulin it makes as well as it should. When there isn't enough insulin or cells stop responding to insulin, too much blood sugar stays in	F 0684		

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F 0684 SS=D	Continued from page 16 your bloodstream. Over time, that can cause serious health problems, such as heart disease, vision loss, and kidney disease. Hypoglycemia is a condition that occurs when blood glucose is lower than normal, usually below 70 milligrams per deciliter (mg/dl). If left untreated, hypoglycemia may lead to weakness, confusion, unconsciousness, arrhythmias and even death. People with Diabetes Mellitus may be prescribed injectable insulin to assist in maintaining acceptable levels of CBG's. Hyperglycemia, or high blood glucose, occurs when there is too much sugar in the blood. This happens when your body has too little insulin. Hyperglycemia is blood glucose greater than 125 mg/dL while fasting (not eating for at least eight hours, or a blood glucose greater than 180 mg/dL one to two hours after eating. If you have hyperglycemia and it 's untreated for long periods of time, you can damage your nerves, blood vessels, tissues and organs. Damage to blood vessels can increase your risk of heart attack and stroke, and nerve damage may also lead to eye damage, kidney damage and non-healing wounds.	F 0684		

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F 0684 SS=D	Continued from page 17 Review of the facility policy "Obtaining a Fingerstick Glucose Level" reviewed 4/1/24 and 3/26/25, indicated the documentation after the procedure should contain all assessment data obtained during the procedure. Document the blood sugar results. Follow facility policies and procedures for appropriate nursing interventions regarding blood sugar results (if resident is on sliding scale coverage, and/or physician intervention is needed to adjust insulin or oral medication dosages), etc. Review of the facility policy "Change in Resident 's Condition or Status" reviewed 4/1/24 and 3/26/25, indicated the nurse will notify the resident 's attending physician or physician on call when there has been a need to alter the resident 's medical treatment significantly. A "significant change" of condition is a major decline or improvement in the resident 's status that will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions. Prior to notifying the physician or healthcare provider, the	F 0684		

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F 0684 SS=D	Continued from page 18 nurse will make detailed observations and gather relevant and pertinent information for the provider. Review of the care plan "Charting and Documentation" reviewed 4/1/24 and 3/26/25, indicated the following information is to be documented in the resident medical record: (a) Objective observations; and (d) Change ' s in resident ' s condition. Documentation of procedures and treatments will include care-specific details, including the assessment data and/or unusual findings obtained by the procedure and notification of family, physician, or other staff, if indicated. Review of the facility policy "Care Plans, Comprehensive Person-Centered" reviewed 4/1/24 and 3/26/25, states a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident ' s physical, psychosocial, and functional needs is developed and implemented for each resident. The comprehensive, person-centered care plan describes the services that are to be furnished to	F 0684		

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F 0684 SS=D	Continued from page 19 attain or maintain the resident ' s highest practicable physical, mental, and psychosocial well-being. When possible, interventions address underlying source(s) of the problem area(s), not just symptoms or triggers. The facility was unable to provide a policy regarding care of the diabetic resident. Review of the clinical record revealed Resident R58 was admitted to the facility on 12/16/24, with diagnoses that included dementia (group of symptoms affecting memory, thinking and social abilities), diabetes, and aphasia (an impairment in a person's ability to comprehend or formulate language because of dysfunction in specific brain regions). Review of Minimum Data Set (MDS - a mandated assessment of a resident's abilities and care needs) dated 5/28/25, indicated the diagnoses remain current.	F 0684		

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F 0684 SS=D	Continued from page 20 Review of Resident R58 physician ' s order revealed the following orders: - On 12/31/24, Humalog (a fast-acting insulin that starts to work about 15 minutes after injection, peaks in about 1 hour, and keeps working for 2 to 4 hours) insulin per sliding scale with meals; For blood sugar 331 and greater, give six units then call MD (doctor). Review of the clinical record, and electronic Medication Administration Record (eMAR) revealed that the resident's CBG's were as follows: - On 5/6/25, at 5:58 p.m. the CBG was noted to be 413. Recheck CBG at 5:59 p.m. was noted to be 413. - On 5/9/25, at 5:50 p.m. the CBG was noted to be 393. Recheck CBG at 6:28 p.m. was noted to be 393. - On 5/12/25, at 7:58 p.m. the CBG was noted to be 397. Recheck CBC at 7:59 p.m. was noted to be 397.	F 0684		

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F 0684 SS=D	Continued from page 21 - On 5/18/25, at 6:08 p.m. the CBG was noted to be 359. Recheck CBG at 6:14 p.m. was noted to be 359. - On 5/26/25, at 5:52 p.m. the CBG was noted to be 354. Recheck CBG at 5:52 p.m. was noted to be 354. - On 5/27/25, at 8:47 a.m. the CBG was noted to be 350. - On 6/1/25, at 6:52 p.m. the CBG was noted to be 438. Recheck CBG at 6:54 p.m. was noted to be 438. - On 6/6/25, at 5:37 p.m. the CBG was noted to be 438. Recheck CBG at 6:54 p.m. was noted to be 438. - On 6/17/25, at 7:36 a.m. the CBG was noted to be 368. - On 6/23/25, at 6:28 p.m. the CBG was noted to be 349. Recheck CBG at 6:31 p.m. was noted to be 349 Review of Resident's eMAR and clinical progress notes indicated the resident was not assessed for hyperglycemia, the blood glucose was not	F 0684		

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F 0684 SS=D	Continued from page 22 monitored for effectiveness of treatment, and the physician was not notified of abnormal results on the above listed date. Review of a clinical record indicated Resident R64 was admitted to the facility on 2/24/22, with diagnoses that included diabetes, depression, and lymphedema (accumulation of protein-rich fluid that's usually drained through the body's lymphatic system, most commonly affects the arms and legs). Review of the MDS dated 5/30/25, indicated the diagnoses remain current. Review of Resident R64 physician ' s orders revealed the following orders: - On 7/16/24, Humalog insulin per sliding scale. For blood sugar 331 and greater, cover with 7 units and call MD for further orders. Review of Resident 64's eMAR revealed that the resident's CBG's were as follows:	F 0684		

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F 0684 SS=D	Continued from page 23 - On 3/26/25, at 11:43 a.m. the CBG was noted to be 334. - On 4/16/25, at 12:41 p.m. the CBG was noted to be 350. - On 5/28/25, at 7:57 a.m. the CBG was noted to be 374. - On 5/29/25, at 8:33 a.m. the CBG was noted to be 375. - On 6/1/25, at 6:58 p.m. the CBG was noted to be 367. Review of the care plan dated 6/17/24, indicated the following interventions: - Diabetes medication as ordered by doctor. Monitor/document for side effects and effectiveness. - Monitor/document/report PRN (as needed) any psychosocial problem areas - Monitor/document/report PRN compliance with diet and document any problems. - Monitor/document/report PRN any sign/symptoms of infection to any open area.	F 0684		

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F 0684 SS=D	Continued from page 24 Review of the care plan revised on 6/5/25, failed to reveal a person-centered care plan with interventions specific to Resident R64. Review of Resident R64's eMAR and clinical progress notes indicated the resident was not assessed for hyperglycemia, the blood glucose was not monitored for effectiveness of treatment, and the physician was not notified of abnormal results on the above listed dates. Review of the clinical record indicated Resident R111 was admitted to the facility on 4/3/25, with diagnoses that included diabetes, aphasia (an impairment in a person's ability to comprehend or formulate language because of dysfunction in specific brain regions), and dysphagia (difficulty swallowing). Review of Resident R111 physician ' s order revealed the following orders:	F 0684		

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F 0684 SS=D	Continued from page 25 - On 4/3/25 through 5/8/25, Humalog insulin per sliding scale. If blood sugar is 341 and greater, give six units and call MD. Review of the clinical record, and electronic Medication Administration Record (eMAR) revealed that the resident's CBG's were as follows: - On 4/4/25, at 12:37 p.m. the CBG was noted to be 408. Recheck CBG at 12:49 p.m. was noted to be 408. - On 5/3/25, at 5:43 p.m. the CBG was noted to be 434. Recheck CBG at 5:43 p.m. was noted to be 434. Review of the care plan dated 1/30/24, indicated the following interventions: - Diabetes medication as ordered by doctor. Monitor/document for side effects and effectiveness. - Monitor/document/report PRN (as needed) any psychosocial problem areas - Monitor/document/report PRN compliance with	F 0684		

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F 0684 SS=D	Continued from page 26 diet and document any problems. - Monitor/document/report PRN any sign/symptoms of infection to any open area. Review of the care plan revised on 4/4/25, failed to reveal a person-centered care plan with interventions specific to Resident R111. Review of Resident's eMAR and clinical progress notes indicated the resident was not assessed for hyperglycemia, the blood glucose was not monitored for effectiveness of treatment, and the physician was not notified of abnormal results on the above listed date. During an interview on 6/25/25, at 10:15 a.m. Licensed Practical Nurse (LPN) Employee E1 stated it depends on the resident 's order for when to notify the doctor. If the blood sugar was below 70, they would provide juice or snack depending on their signs and symptoms. If the blood sugar was greater that 300, they would give the resident water, the ordered insulin, and assess the resident to see if	F 0684		

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F 0684 SS=D	Continued from page 27 signs and symptoms were present, they would notify the doctor. They stated they would document in the eMAR and progress notes. During an interview on 6/25/25, at 10:05 a.m. Registered Nurse (RN) Employee E2 stated for blood sugar less than 70, they would call the doctor and give a snack or juice. If the blood sugar was over 330, they would give the ordered insulin, call the doctor, check the resident ' s vital signs. They would document in the eMAR and a progress note. During an interview on 6/25/25, at 10:08 a.m. RN Employee E3 stated if the blood sugar was less that 70 or over 400, they would notify the doctor. If the blood sugar was less than 70, they would provide a snack or juice and recheck the blood sugar in 15 minutes. If the blood sugar was over 400, they would check the resident ' s vital signs, assess the resident for any signs and/or symptoms, and call the doctor. They would document in the eMAR and progress notes.	F 0684		

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F 0684 SS=D	Continued from page 28 During an interview on 6/25/25, at 10:10 a.m. LPN Employee E4 stated if the resident ' s blood sugar was less than 60, they would provide a snack or juice and call the doctor if the blood sugar did not During an interview on 6/25/25, at 10:15 a.m. RN Employee E5 stated they would check the doctor ' s orders to check when to notify the doctor. If the blood sugar was less than 70, they would assess the resident for signs and symptoms and provide a snack or juice. For blood sugar over 140, they would monitor the resident. They would document in the eMAR and progress notes. During an interview on 6/26/25, at 10:00 a.m. the Director of Nursing confirmed the facility failed to notify the doctor of a change in condition, failed to document an assessment or interventions used related to blood glucose, and failed to follow physicians orders for Residents R58, R64, and R111. 28 Pa. Code 201.18 (b)(1) Management	F 0684		

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F 0684 SS=D	Continued from page 29 28 Pa. Code 201.29(d) Resident rights 28 Pa. Code 211.10 (c)(d) Resident care policies 28 Pa. Code 211.12 (d)(1)(2)(3)(5) Nursing services	F 0684		
F 0689 SS=E		F 0689		

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F 0689 SS=E	Continued from page 30 483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2) Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by:	F 0689	All items cited on the Willow unit were removed from the shelving/drawers and outlet covers were installed immediately. R225 did not sustain any injury due to removing their security bracelet with nail clippers. Nurse statement revealed family member admitted to bringing the clippers and they were immediately removed warranting no further investigation. Rounds were completed in each room of the Willow unit to ensure no hazardous items were present. No further items were discovered. NHA or designee will educate memory care staff on maintaining a hazard free environment. Unit Manager or designee will audit the unit for potential hazards twice weekly x 4 weeks, then monthly x 2 months. Results will be reviewed at QAPI and revised as needed.	Completion Date: 08/03/2025 Status: APPROVED Date: 07/11/2025

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F 0689 SS=E	Continued from page 31 Based on review of the facility policy, observations, clinical record review, review of facility document and staff interviews, it was determined that the facility failed to provide an environment free from potential accident hazards due to uncovered electrical plugs, accessible potential hazardous materials, foods and sharps that had potential to cause injury and actual removal of a elopement bracelet for one resident (Resident R225) on one of four nursing units(Memory Care Unit). Findings include: Review of the facility policy "Accidents and Incidents-Investigating and Reporting" dated 3/26/25, with a previous review date of 3/1/24, indicated that all accidents or incidents involving residents occurring on the premises shall be investigated and reported. the investigation shall be initiated promptly and documented on the "Report of Incident/Accident Form". During an observation of the Secured Memory Care	F 0689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395391	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 06/26/2025	
NAME OF PROVIDER OR SUPPLIER: ASBURY HEALTH CENTER STATE LICENSE NUMBER: 132602		STREET ADDRESS, CITY, STATE, ZIP CODE: 700 BOWER HILL ROAD PITTSBURGH, PA 15243		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0689 SS=E	<p>Continued from page 32</p> <p>Nursing Unit on 6/23/25, from 11:26 a.m., through 11:48 a.m., the following was identified:</p> <p>Three plug outlets in the right wing hallway had no covers with exposed wiring.</p> <p>An unsecured room identified as the Activity Room had shelving/drawer units with five unsecured drawers four of which had packages of wipes, two pretzels, clips, hand sanitizer packs and sugar packs, paper files which the sharp file holder metal bar fell off, within the drawer also was a roll of tape, paperclips and binding clips and other unidentifiable items. The cabinet contained two electrical extension cords and a coiled wire for an unidentified item.</p> <p>During the observation, Resident R97 was in the hall attempting to wheel his wheelchair throughout the hallway.</p> <p>During an interview on 6/23/25, at 11:33 a.m., Registered Nurse Employee E11 confirmed that the facility failed to provide an environment free from</p>	F 0689		

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F 0689 SS=E	Continued from page 33 potential accident hazards. During a clinical record review Resident R225 was admitted to the facility on 6/14/25, with diagnoses which included dementia, anxiety, insomnia and kidney disease. Resident R225 was identified as requiring placement on the memory care secured unit. Review of a physician order dated 6/14/25, indicated placement of a wanderguard bracelet and placement checked each shift for security. Review of a progress noted dated 6/18/25, at 1:34 p.m., indicated Resident R225 had cut off the wanderguard bracelet with nail clippers and the nurse had taken the clippers and replaced the bracelet. During an interview on 6/24/25, at 2:50 p.m., the Nursing Home Administrator(NHA) and Director of Nursing stated that the incident was put the information on a "Incident Statement Form" by the	F 0689		

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F 0689 SS=E	Continued from page 34 nurse however, the incident investigation did not take place. The NHA confirmed that the facility failed to provide an environment free from potential accidents hazards. 28 Pa. Code 201.14(a)(c)(e) Responsibility of licensee 28 Pa. Code 201.18(b)(1)(3)(e)(1) Management 28 Pa. Code 211.10(d) Resident care policies	F 0689		

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F 0689 SS=E	Continued from page 35	F 0689		
F 0690 SS=D		F 0690		

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F 0690 SS=D	Continued from page 36 483.25(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	R331's MD was notified of concern having orders for output, measuring and recording of urinary output for resident's catheter management. R51 was provided with a foley privacy bag. All residents with foley catheters were audited for privacy bags and foley management orders reviewed to ensure output documentation within a 24-hour period is inclusive. DON or designee will educate nurses on proper foley catheter management including documentation of output for all residents with a foley catheter and proper placement of catheters in a dignity bag. Facility IP or designee will audit all foley catheter residents for appropriate chart documentation and privacy bags 1 time a week for 4 weeks, then monthly for 2 months. Results will be reviewed at QAPI and revised as needed.	Completion Date: 08/03/2025 Status: APPROVED Date: 07/11/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395391	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 06/26/2025
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F 0690 SS=D	Continued from page 37 This REQUIREMENT is not met as evidenced by:	F 0690		

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F 0690 SS=D	Continued from page 38 Based on review of facility policies, observations, clinical records, and staff interviews it was determined that the facility failed to make certain that appropriate treatments and services were provided for the use of an indwelling urinary catheter as required for two of four residents (Resident R51 and R331). Findings include: Review of the facility policy "Indwelling (Foley) Catheter Removal" dated 3/26/25, indicated documentation in the medical record should consist of the following: date and time the procedure was performed, name and title of the individual who performed the procedure, all assessment data (urine amount, color, clarity, etc.) obtained during procedure, time and amount of first void after catheter removal, how the resident tolerated the procedure, if resident refused the procedure, reason and interventions taken, signature and title of person recording data.	F 0690		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395391	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 06/26/2025	
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F 0690 SS=D	<p>Continued from page 39</p> <p>Review of the facility policy "Output, Measuring and Recording" dated 3/26/25, indicated this procedure is to accurately determine the amount of urine that a resident excretes in a 24 hour period.</p> <p>Review of the facility policy "Urinary Continence and Incontinence-Assessment and Management" dated 3/26/25, indicated the staff and practitioner will appropriately screen for, and manage individuals with urinary incontinence. Management of incontinence will follow relevant clinical guidelines. The physician and staff will provide appropriate services and treatments to help residents restore or improve bladder function and prevent urinary tract infections to the extent possible. Indwelling urinary catheters will be used sparingly, for appropriate indications only. Identification and management of urinary tract infections will follow relevant clinical guidelines. Antibiotics will be used appropriately.</p> <p>Review of Resident R51's medical record indicated admission to the facility on 6/2/25, with diagnoses that include history of falling, chronic kidney disease</p>	F 0690		

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F 0690 SS=D	Continued from page 40 (longstanding disease of the kidneys leading to kidney failure), urinary tract infection, and obstructive and reflux uropathy (two distinct conditions of the urinary tract where one causes a blockage allowing for normal flow and the other causing urine in the bladder to the back up into the kidneys). Review of Resident R51's Minimum Data Set (MDS-a periodic assessment of care needs) dated 6/9/25, indicates the diagnoses are current. Review of Resident R331's medical record indicated admission to the facility on 6/9/25, with diagnoses that include history of falling, obstructive and reflux uropathy, urinary tract infection, and cognitive communication deficit (difficulties in communication due to impairments in cognitive processes like attention, memory, and problem-solving, rather than primary speech or language disorders). Review of Resident R331's MDS dated 6/16/25,	F 0690		

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F 0690 SS=D	Continued from page 41 indicates the diagnoses are current. Review of Resident R331's clinical record indicated the foley catheter was to be discontinued on 6/23/25, review of the record revealed that bladder scans were ordered every shift for 72 hours with resident to receive a straight catheter (temporary catheter used once to empty the bladder and then removed immediately) for residual of greater than 450 milliliters. Review of Resident R331's clinical record indicated the resident was not offered attempts to toilet more frequently per policy for post removal of catheter, incontinent without measurement (resident also had order to push fluid of 250 milliliters every 2 hours while awake), and no documentation of staff's assistance in resident's continence/incontinence per policy. Review of Resident R331's clinical record indicated resident had to have foley replaced on 6/24/25, due to inability to empty bladder completely.	F 0690		

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F 0690 SS=D	<p>Continued from page 42</p> <p>Observation on 6/23/25 at approximately 1:30 p.m. Resident R51 was noted up in wheelchair with foley bag hanging on side of wheelchair with no dignity bag for privacy. Resident R331 was noted to be in bed with foley bag hanging on side of bed with no dignity bag for privacy.</p> <p>Observation on 6/25/25 at 12:40 p.m., noted Resident R51 sitting in wheelchair with foley hanging on walker with dignity bag next to it. Resident R331 was noted in bed with foley hanging on side of bed with no dignity bag in place.</p> <p>Interview with Nurse Aide (NA) Employee E12 on 6/25/25 at 12:40 p.m. confirmed the catheter drainage bag facing entrance door on the walker and bed frame were not covered with a dignity bag for privacy as required.</p> <p>Interview with Director of Nursing (DON) on 6/26/25, at 10:15 a.m. confirmed the facility failed to ensure that appropriate treatment and services</p>	F 0690		

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F 0690 SS=D	Continued from page 43 were provided for two of four residents (Resident R51 and R331) with an indwelling urinary catheter. 28 Pa. Code 201.18(b)(1) Management. 28 Pa. Code 211.10(c)(d) Resident care policies. 28 Pa. Code 211.12(a)(c)(d)(1)(2)(5) Nursing services.	F 0690		
F 0756 SS=D		F 0756		

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F 0756 SS=D	Continued from page 44 483.45(c)(1)(2)(4)(5) Drug Regimen Review, Report Irregular, Act On §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record.	F 0756	R58 will have a pharmacy review completed and reviewed by MD. An audit of all other residents was conducted to identify those out of compliance with pharmacy reviews and all identified residents will have a pharmacy review completed and reviewed by MD. Unit Managers will be educated on the need for monthly pharmacy review compliance and assisting with physician follow up until completion is documented in resident charts. Unit Managers or designee will audit monthly pharmacy reviews weekly x 4 weeks, then monthly x 2 months. Results will be reviewed at QAPI and revised as needed.	Completion Date: 08/03/2025 Status: APPROVED Date: 07/11/2025

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F 0756 SS=D	Continued from page 45 §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by:	F 0756		
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F 0756 SS=D	Continued from page 46 Based on review of facility policy, clinical record review and staff interview, it was determined that the facility failed to ensure the pharmacy completed a Medication Regime Review (MRR) at least monthly for one of five residents (Resident R58). Findings: Review of facility policy "Medication Regimen Review" reviewed 4/1/24 and 3/26/25, indicated the consultant pharmacist performs a MRR for every resident in the facility receiving medications. Medication regimen reviews are done upon admission and at least monthly thereafter, or more frequently if indicated. Copies of MRR reports, including physician responses, are maintained as part of the permanent medical record. Review of the clinical record revealed Resident R58 was admitted to the facility on 12/16/24, with diagnoses that included dementia (group of symptoms affecting memory, thinking and social abilities), diabetes, and aphasia (an impairment in a	F 0756		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395391	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 06/26/2025
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F 0756 SS=D	Continued from page 47 person's ability to comprehend or formulate language because of dysfunction in specific brain regions). Review of Minimum Data Set (MDS - a mandated assessment of a resident's abilities and care needs) dated 5/28/25, indicated the diagnoses remain current. Review of Resident R58 clinical record failed to indicate a MRR was completed for February 2025, March 2025, and May 2025. During an interview on 6/26/25, at 10:15 a.m. the Nursing Home Administrator (NHA) confirmed the facility failed to complete monthly pharmacy MRR's for Resident R58.	F 0756		
F 0812 SS=F		F 0812		

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F 0812 SS=F	Continued from page 48 483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by:	F 0812	E13 was immediately educated on proper food handling procedures on tray line and infection control standards. The bread bags and bowls were removed from the tray line after discovery. CDM or designee will educate all kitchen staff on proper food handling procedures. CDM or designee will audit tray line during meal service 3 times a week for 4 weeks, then twice a month for 2 months. Results will be reviewed at QAPI and revised as needed.	Completion Date: 08/03/2025 Status: APPROVED Date: 07/11/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395391	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 06/26/2025	
NAME OF PROVIDER OR SUPPLIER: ASBURY HEALTH CENTER STATE LICENSE NUMBER: 132602		STREET ADDRESS, CITY, STATE, ZIP CODE: 700 BOWER HILL ROAD PITTSBURGH, PA 15243		
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F 0812 SS=F	Continued from page 49 Based on review of facility policies, observations and staff interview, it determined the facility failed to maintain sanitary conditions to prevent the potential for cross contamination during lunch time tray line. Findings include: Review of a facility policy " Food Preparation and Service" dated 3/26/25, indicated that food preparation staff adhere to proper hygiene and sanitary practices to prevent the spread of food borne illness. Bare hand contact with food is prohibited. Gloves are to be worn when handling food directly and changed between tasks. During an observation on 6/23/25, from 10:48 a.m., through 11:28 a.m., the following was identified: Dietary Aide Employee E13 had three racks/trays of bowls leaning over food items on the steam table while food was being plated. Dietary Aide Employee E14 had gloves on touching	F 0812		

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F 0812 SS=F	Continued from page 50 the outer surfaces of bags of buns, removing a bun, plating it then with same gloved hands picking up lettuce and tomatoes and placing it on the burger, was also turning around opening packages of buns and cheese then returning and placing them on burgers with no glove change and/or hand washing between tasks. During an interview on 6/23/25, at 11:28 a.m., Interim Dietary Manager Employee E15 confirmed that the facility failed to maintain sanitary conditions to prevent the potential for cross contamination during lunch time tray line. 28 Pa. Code: 211.6 (c)(f) Dietary services.	F 0812		
F 0836 SS=D		F 0836		

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F 0836 SS=D	Continued from page 51 483.70(a)-(c) License/Comply w/ Fed/State/Loel Law/Prof Std §483.70(a) Licensure. A facility must be licensed under applicable State and local law. §483.70(b) Compliance with Federal, State, and Local Laws and Professional Standards. The facility must operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility. §483.70(c) Relationship to Other HHS Regulations. In addition to compliance with the regulations set forth in this subpart, facilities are obliged to meet the applicable provisions of other HHS regulations, including but not limited to those pertaining to nondiscrimination on the basis of race, color, or national origin (45 CFR part 80); nondiscrimination on the basis of disability (45 CFR part 84); nondiscrimination on the basis of age (45 CFR part 91); nondiscrimination on the basis of race, color, national origin, sex, age, or disability (45 CFR part 92); protection of human subjects of research (45 CFR part 46); and fraud and abuse (42 CFR part 455) and protection of individually identifiable health information (45 CFR parts 160 and 164). Violations of such other provisions may result in a finding of non-compliance with this paragraph.	F 0836	Facility will maintain new hire lists and training records in a central location monthly to ensure information readily available. Copies of resident investigations will be maintained in the NHA office for ease of access during survey moving forward. NHA or designee will educate HR Director on new hire file checklist and maintaining employee lists. NHA or designee will educate the DON on maintaining annual education centrally and accurately for all staff for ease of review. ED or designee will educate NHA on maintaining resident investigations. For auditing timely provision of requested information to the surveyor team, the facility will audit the following areas. HR or designee will audit new hire files weekly x 4 weeks, then monthly x 2 months for compliance. Facility staff educator or designee will audit employee education weekly x 4 weeks, then monthly x 2 months for compliance. NHA will audit resident investigations weekly x 4 weeks,	Completion Date: 08/03/2025 Status: APPROVED Date: 07/15/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395391	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 06/26/2025
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F 0836 SS=D	Continued from page 52 This REQUIREMENT is not met as evidenced by:	F 0836	then monthly x 2 months. Results will be reviewed at QAPI and revised as needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395391	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 06/26/2025	
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F 0836 SS=D	Continued from page 53 Based on a review of facility documents and interviews with staff it was determined that the facility failed to provide the State Agency with access to facility information, causing a delay in the survey process. Findings include: During the entrance conference on June 23, 2025, the Nursing Home Administrator(NHA) and Director of Nursing(DON) were provided information requesting a list of new hires in the last four months as identified on the state entrance conference form including any contracted employees and also an all house employee list and their date of hire for annual education purposes. Review of the five new hire personnel files requested on 6/24/25, at 10:40 a.m., were not received until 1:30 p.m. a second request for Human Resources(HR) Employee E16 at 2:15 p.m., due to information related to expired licenses on file, documentation of employee physicals, employees	F 0836		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395391	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 06/26/2025	
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F 0836 SS=D	Continued from page 54 reference checks and documentation of employees receiving facility orientation was made. On 6/25/25, at 8:20 a.m., the New Employee Files were not provided until 9:20 a.m. New Employee file review again still incomplete with new hire orientation documentation still not identified. The State Agency (SA) had to find the information with another new employee file review as HR Employee E16 did not provide the information., adding another hour to the review. Review of 10 employees annual educational records requested on 6/24/25, at 10:40 a.m., were received at 1:30 p.m., and did not include 12 hours of annual trainings for the five Nurse Aides and for all 10 employees did not include all required trainings. The NHA was asked again for complete documentation of their education's and any additional information to assist in producing the trainings and the 12 hour need for Nurse Aides as required. on 6/24/25, at 2:15 p.m., the second request for the information was placed. On 6/25/25, at 9:20 a.m., the information was reviewed and documentation for	F 0836		

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F 0836 SS=D	Continued from page 55 four employees including two Nurse Aides(NA), a Therapy staff person and a Registered Nurse(RN) was not included. Additional information was not provided until 1:43 p.m. At this time the facility Executive Director stated "We are at 100 percent compliance, we have emails from two staff (one NA and the RN)stating they completed the trainings, they were here at the time of trainings onsite but did not complete them and did them at home, why are you picking this apart?". Additional information was not provided. During an interview on 6/26, at 9:16 a.m., the NHA was asked to provide an investigation for Resident R39 and a staffing deployment sheet for 6/18/25, the documentation for Resident R39 was not provided until 10:16 a.m., an hour later. During the exit conference, the facility was made aware that the surveyor completing the tasks for new employee files and employee education had stated the multiple requests for information that should readily be available due to the annual process	F 0836		

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F 0836 SS=D	Continued from page 56 being unchanged was delaying the survey process. 28 Pa.Code 201.14(a) Responsibility for licensee. 28 Pa.Code 201.18(d)(e)(1) Management.	F 0836		
F 0883 SS=D		F 0883		

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F 0883 SS=D	Continued from page 57 483.80(d)(1)(2) Influenza and Pneumococcal Immunizations §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization;	F 0883	R53's POA will be contacted to offer a pneumococcal vaccine. During next flu season, facility will ensure the POA is notified if resident refuses a flu vaccine. A full house audit of all residents will be conducted to ensure all residents are offered appropriate vaccines and educated accordingly. If residents are not capable of making their own decisions, their legal representative will be notified to offer the vaccines and education. DON or designee will educate the facility IP on maintaining documentation of offering the influenza and pneumococcal vaccines on admission and annually. Facility IP or designee will audit all new admissions for documentation of the influenza and pneumococcal vaccine being offered weekly x 4 weeks, then monthly x 2 months. Results will be reviewed at QAPI and revised as needed.	Completion Date: 08/03/2025 Status: APPROVED Date: 07/11/2025

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F 0883 SS=D	Continued from page 58 (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by:	F 0883		

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F 0883 SS=D	Continued from page 59 Based on a review of select facility policies and procedures, current Centers for Disease Control (CDC) guidelines, clinical record review, and staff interview, it was determined that the facility failed to document each resident was offered an influenza and/or pneumococcal immunization and the resident or resident's representative was provided education regarding the benefits and potential side effects of immunizations, for one of five residents reviewed for influenza and pneumococcal immunizations (Resident R53). Findings include: A review of facility policies, "Pneumococcal Vaccine" and "Influenza Vaccine," dated 4/1/24, indicated vaccines are administered in accordance with Centers for Disease Control and Prevention (CDC) recommendations. All residents are offered pneumococcal and influenza vaccines to aid in preventing infections. The resident or resident's legal representative will be provided information and education regarding the benefits and potential side	F 0883		

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F 0883 SS=D	Continued from page 60 effects of the vaccines and will be documented in the medical record. A review of the clinical record indicated Resident R53 was admitted to the facility on 6/19/19, with diagnoses that included dementia and high blood pressure. A review of the Minimum Data Set (MDS - periodic assessment of care needs) dated 4/15/24, indicated the resident had severely impaired cognition, did not receive the influenza vaccine, and was not offered the pneumococcal vaccine. A review of the electronic clinical record "Immunizations" documentation on 6/25/25 at 11:00 a.m., did not include information that the influenza or pneumococcal vaccines were offered or declined. A review of a nurse progress note dated 10/18/24, indicated the resident refused the flu vaccine. There was no documentation in the clinical record that the resident's legal representative was provided information and education regarding the benefits and	F 0883		

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F 0883 SS=D	Continued from page 61 potential side effects of the vaccines or notification that the vaccines were offered or declined. During an interview on 6/25/25 at 11:45 a.m., the Director of Nursing confirmed the above findings, and that the facility failed to document each resident was offered an influenza and/or pneumococcal immunization and the resident or resident's representative was provided education regarding the benefits and potential side effects of immunizations, for Resident R53. 28 Pa. Code 211.5(f)(i)-(xi) Medical records. 28 Pa. Code 211.12(d)(1)(5) Nursing services	F 0883		



Certified End Page

ASBURY HEALTH CENTER

STATE LICENSE NUMBER: 132602

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**

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