STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395423	A. BLDG: 00 B. WING:	02/07/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
CORNER VIEW NURSING AND REHABILITATION CENTER STATE LICENSE NUMBER: **060402**	**6655 FRANKSTOWN AVENUE PITTSBURGH, PA 15206**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0000	INITIAL COMMENT Based on an Medicare/Medicaid Recertification, State Licensure, Civil Rights Compliance survey and an abbreviated survey in response to six complaints completed on February 7, 2025, it was determined that Corner View Nursing and Rehabilitation Center 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 0554 SS=D		F 0554		

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 0554 SS=D	Continued from page 1 483.10(c)(7) Resident Self-Admin Meds-Clinically Approp §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by:	F 0554	The medications for Residents R143 and R318 were immediately removed from the resident's room. An assessment of both residents was completed to determine whether they could safely self-administer medications. An initial audit will be completed by DON/designee of current resident rooms to ensure there are no unsecured medication and that there is a self-administration of medication assessment completed for any resident self-administering his/her own medications. Licensed nursing staff re-education will be conducted by the DON/designee on self-administration of medications by a resident. The DON/designee will complete an audit of 5 medication passes specific to nurses leaving meds at bedside for 2 weeks, then 5 medication passes monthly for 2 months to ensure there are no medications left	Completion Date: **03/17/2025** Status: **APPROVED** Date: **02/26/2025**

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F 0554 SS=D	Continued from page 2	F 0554	at beside without an order. Results of audits will be reported by DON/designee monthly to the Quality Improvement Committee (QIC) for review and recommendation then randomly thereafter as determined by the QIC committee.	

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F 0554 SS=D	Continued from page 3 Based on review of facility policies, observations, and resident and staff interviews, it was determined that the facility failed to determine the ability to safely self-administer medications for two of six residents reviewed (Resident R143, and R318). Findings include: Review of the facility's policy "Self-Administration of Medication" last reviewed 2/3/25, indicated residents have the right to self-administer medications if the interdisciplinary team has determined it is clinically appropriate and safe for the resident to do so. The staff and practitioner will document their findings and the choices of residents who are able to self-administer medications. Review of the admission record indicated Resident R143 was admitted to the facility on 7/10/23. Review of Resident R143's Minimum Data Set (MDS - a periodic assessment of care needs) dated 11/5/24, indicated the diagnoses of	F 0554		

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F 0554 SS=D	Continued from page 4 Non-Alzheimer's Dementia (dementia caused by other diseases with symptoms forgetfulness, limited social skills, and impaired thinking abilities that interfere with daily functioning), seizure disorder (a person experiences abnormal behaviors, symptoms and sensations, sometimes including loss of consciousness), and schizophrenia (characterized by thoughts or experiences that seem out of touch with reality, disorganized speech or behaviors, and decreased participation in activities of daily living). Review of Resident R143's physician orders dated 2/1/25, indicated lactulose (medication that treats liver disease) 30 mls (milliliters) twice daily for treatment of cirrhosis of the liver (diseased liver), and failed to indicate an order for self-administration of medications. Review of Resident R143's care plan dated 1/14/24, indicated to give medications as ordered, and failed to include a goal or interventions for self-administration of medications.	F 0554		

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F 0554 SS=D	Continued from page 5 Review of assessments indicated that an assessment to safely self-administer medications was not completed. Observations of Resident R143's overbed table on 2/3/25, at 9:29 a.m. revealed a medication cup filled with a green liquid. Interview on 2/3/24, at 9:45 a.m. Licensed Practical Nurse (LPN) Employee E7 confirmed the medication cup was Resident R143's lactulose. Review of the admission record indicated Resident R318 was admitted to the facility on 1/16/25. Review of Resident R318's MDS dated 1/23/25, indicated the diagnoses of high blood pressure, atrial fibrillation (irregular heart rhythm), and heart failure (heart doesn't pump blood as well as it should). Review of Resident R318's physician orders dated 1/16/25, indicated albuterol (medication to assist in breathing) aerosol two puffs every four hours as	F 0554		

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F 0554 SS=D	Continued from page 6 needed for wheezing, and failed to indicate an order for self-administration of medications. Review of Resident R318's care plan dated 1/22/25, indicated to give aerosol or bronchodilators (relaxes muscles in the airway making it easier to breathe) as ordered, and failed to include a goal or interventions for self-administration of medications. Review of assessments indicated that an assessment to safely self-administer medications was not completed. Observations of Resident R318's overbed table on 2/3/25, at 9:32 a.m. revealed an albuterol inhaler on resident's nightstand. Interview on 2/3/24, at 9:45 a.m. Licensed Practical Nurse (LPN) Employee E7 confirmed the albuterol inhaler was sitting on resident's nightstand. Interview on 2/3/25, at 2:00 p.m. the Director of	F 0554		

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F 0554 SS=D	Continued from page 7 Nursing, confirmed the facility failed to determine the ability to safely self-administer medications for two of six residents reviewed (Resident R143, and R318). 28 Pa. Code: 211.10(c)(d) Resident care policies. 28 Pa. Code: 211.12(d)(1)(2)(3)(5) Nursing services.	F 0554		
F 0570 SS=C		F 0570		

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F 0570 SS=C	Continued from page 8 483.10(f)(10)(vi) Surety Bond-Security of Personal Funds §483.10(f)(10)(vi) Assurance of financial security. The facility must purchase a surety bond, or otherwise provide assurance satisfactory to the Secretary, to assure the security of all personal funds of residents deposited with the facility. This REQUIREMENT is not met as evidenced by:	F 0570	No residents were negatively affected by surety bond not having sufficient coverage. A surety bond in the amount of $450,000 will be obtained for the resident trust account at the facility by March 4, 2025.This surety bond will cover the resident trust account at the facility along with all of the individual accounts that each resident has. The Business Office staff will be re-educated on the need for surety bonds to cover the resident trust accounts along with all the individual accounts that each resident has. An audit will be performed on a semi-annual basis beginning on or before March 4, 2025 by the nursing home administrator/designee, to ensure that the surety bond on the resident trust account is current and adequately covered by the surety bonds.	Completion Date: **03/17/2025** Status: **APPROVED** Date: **02/26/2025**

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F 0570 SS=C	Continued from page 9 Based on review of facility documentation and staff interviews it was determined that the facility failed to ensure that the surety bond had sufficient funds to cover the residents personal funds for three of three months (November 2024, December 2024, and January 2025). Findings include: Review of facility bank statements indicated: November 2024 - $409,305.82 December 2024 - $406,090.88 January 2025 - $405,479.42 Review of facility surety bond indicates the amount covered equaled$300,000. During an interview on 2/6/25, at 11:31 a.m. Regional Business Office Manger confirmed that the facility failed to ensure that the surety bond covered the resident trust fund for November 2024, December 2024 and January 2025.	F 0570		

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F 0570 SS=C	Continued from page 10 28 Pa.Code 201.14(a)Responsibility of licensee. 28 Pa. Code 201.18(b)(2)Management.	F 0570		
F 0585 SS=E		F 0585		

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F 0585 SS=E	Continued from page 11 483.10(j)(1)-(4) Grievances §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance	F 0585	Residents will be educated on the facility Grievance Policy in writing and at the monthly Resident Council meeting by the Grievance Coordinator (Social Worker). The education will include the locations of the posted Grievance Policy, the process to file an anonymous grievance, the location of grievance forms and drop off locations, and the name of the grievance coordinator along with his/her name, business phone number, business address and email address. The administrator will ensure that the Grievance Policy is posted on each nursing unit with the grievance forms, drop-off box, the name of the grievance coordinator along with a business phone number, business address, and email address. Social Workers will be educated by the Administrator on the Grievance Policy, where it needs to be posted along with the grievance forms, drop-off boxes, and the posting indicating how to reach the	Completion Date: **03/17/2025** Status: **APPROVED** Date: **02/26/2025**

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F 0585 SS=E	Continued from page 12 can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the	F 0585	Grievance Coordinator (Social Worker) via letter, phone and email. On a daily basis, the Grievance Coordinator will audit each location to ensure the grievance policy and grievance coordinator information remains posted when he/she is collecting completed grievance forms from the drop-off box.	

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F 0585 SS=E	Continued from page 13 date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by:	F 0585		

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F 0585 SS=E	Continued from page 14 Based on policy, resident and staff interview interviews, and observations it was determined that the facility failed to make certain the grievance policy was posted prominently throughout the facility, failed to include an anonymous place and the address, email and phone number for the grievance officer for 5 of 5 nursing units. Findings include: §483.10(j) Grievances. §483.10(i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance.	F 0585		

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F 0585 SS=E	Continued from page 15 Review of facility policy "Filing Grievances/Complaints" dated 2/3/25, indicated "Our facility will help residents, their representatives (sponsors), other interested family members, or resident advocates file grievances or complaints when such requests are made." Resident group on 2/4/25, at 10:30 a.m. indicated they were unaware of the grievance policy and procedure and how to file anonymously. During observations on 2/6/25, from 1:05 p.m. to 1:38 p.m. on second floor nursing unit to sixth floor nursing unit failed to include the grievance policy posted throughout the facility, failed to include how and where an anonymous place to file grievances were located. The posting for grievance failed to include the business address, email, and phone number. During an interview on 2/7/25, at 11:44 a.m. Director of Social Services Employee E8 confirmed that the facility failed to make certain that the	F 0585		

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NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
CORNER VIEW NURSING AND REHABILITATION CENTER STATE LICENSE NUMBER: **060402**	**6655 FRANKSTOWN AVENUE PITTSBURGH, PA 15206**

(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 0585 SS=E	Continued from page 16 grievance policy was posted prominently throughout the facility failed to include an anonymous place for grievances, failed to include all the required information to include address, email and phone number for grievance officer. 28 Pa. Code 201.29(1)Resident rights. 28 P. Code 201.18 (e)(4)Management.	F 0585		
F 0610 SS=D		F 0610		

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 0610 SS=D	Continued from page 17 483.12(c)(2)-(4) Investigate/Prevent/Correct Alleged Violation §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by:	F 0610	Resident R24 was no longer in the facility to complete an assessment and interview to rule out abuse or neglect. Other residents who sustained a fall within the one week prior to the fall sustained by Resident R24 will be interviewed by the Director of Nursing (DON)/ designee to determine the cause of the fall and rule out abuse or neglect. Nursing staff will be educated by the DON on the need to immediately initiate an investigation as to the reason for a resident's fall in order to rule out abuse or neglect. The education will include the details of completing a proper investigation including a physical assessment of the resident for injury, an interview with the resident to glean the possible cause of the fall, an assessment of resident's surroundings at the time of the fall, and interviews with obtained statements with the roommate, other residents, and all staff working in the	Completion Date: **03/17/2025** Status: **APPROVED** Date: **02/26/2025**

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 0610 SS=D	Continued from page 18	F 0610	area at the time of the fall in order to rule out abuse or neglect. Audits will be completed of all resident falls 2 weeks prior Resident R24's fall to ensure an investigation was completed as the cause of the fall to rule out abuse or neglect. All future falls will be reviewed at the weekly falls committee to ensure a complete investigation as to the reason of the fall was completed in order to rule out abuse or neglect. The results of the education and audits will be shared at the monthly QAPI meeting for review and approval.	

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F 0610 SS=D	Continued from page 19 Based on review of facility policy, clinical record review and staff interview, it was determined that the facility failed to fully investigate an incident to eliminate possible abuse or neglect for one of three residents (Resident R24). Findings include: Review of the facility policy "Abuse Investigation and Reporting" reviewed 1/15/24, indicated if an incident or suspected incident of resident abuse, mistreatment, neglect, or injury of unknown source is reported, the administrator will assign the investigation to an appropriate individual. The investigation must include interviews of any witnesses to the incident, the resident's roommate, family, and staff members on all shifts who have had contact with the resident during the period of the alleged incident. "Witness reports will be obtained in writing. Either the witness will write his/her statement and sign and date it, or the investigator may obtain a statement, read it back to the member and have him/her sign and date it."	F 0610		

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F 0610 SS=D	Continued from page 20 Review of the facility policy "Assessing Falls and Their Causes" reviewed 1/15/24, indicated falls are a leading cause of morbidity and mortality among the elderly in nursing homes. The incident report form should be completed by the nursing supervisor on duty at the time and submitted to the Director of Nursing. A review of the clinical record indicated Resident R24 was admitted to the facility on 11/2/18, and readmitted 1/19/24, with diagnoses that included high blood pressure, dislocation of right shoulder joint, and diabetes. Review of Residents R24's Minimum Data Set (MDS - a periodic assessment of care needs) dated 12/11/24, indicated diagnoses were current. Section GG- Functional Abilities GG0170. Mobility indicated the resident was dependent with the ability to roll from lying on back to left and right side, and return to lying on back of bed.	F 0610		

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F 0610 SS=D	Continued from page 21 A review of facility records indicated on 1/28/25, Resident R24 was turned on her side with an assist of one person, left unattended, and fell out of bed. The facility failed to provide evidence post-fall monitoring occurred as required. Resident R24 was found unresponsive on 1/29/25, and ceased to breathe at 5:41 a.m. The facility failed to investigate the incident to eliminate possible abuse or neglect. The facility failed to obtain any statements that were both signed and dated by the witnesses. No information was provided for Resident R24's roommate or LPN, Employee E5 who was the nurse assigned to her care from 11:00 p.m. on 1/28/25, until 7:00 a.m. on 1/29/25. The incident was not fully investigated to rule out abuse or neglect. During an interview on 2/4/25, at 11:33 a.m. the Nursing Home Administrator confirmed Resident R24's incident was not fully investigated, and the facility failed to obtain statements that were both signed and dated by the witness.	F 0610		

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F 0610 SS=D	Continued from page 22 28 Pa. Code: 201.149(a) Responsibility of licensee. 28 Pa. Code: 201.18(e)(1) Management.	F 0610		
F 0622 SS=E		F 0622		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0622 SS=E	Continued from page 23 483.15(c)(1)(i)(ii)(2)(i)-(iii) Transfer and Discharge Requirements §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D) The health of individuals in the facility would otherwise be endangered; (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or (F) The facility ceases to operate. (ii) The facility may not transfer or discharge the resident	F 0622	Resident R80 and Resident R124 both returned to the facility and experienced no negative outcome from the deficient practice. Resident R105 did not return. Nursing staff will be educated on the need to transfer Residents with specific healthcare information to meet the resident's specific needs including the Resident's Representative, advanced directives, care plan goals, and specific instructions to provide for his/her care needs. Nursing staff will be required to document in the medical record that upon discharge, Residents were transferred with healthcare related documents including healthcare information to meet the resident's specific needs, the Resident's Representative, advanced directives, care plan goals, and specific instructions to provide for his/her care needs. The DON will review all transfers daily at the clinical meeting to ensure the documentation was	Completion Date: **03/17/2025** Status: **APPROVED** Date: **02/26/2025**

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F 0622 SS=E	Continued from page 24 while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose. §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i) (A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (i) Documentation in the resident's medical record must include: (A) The basis for the transfer per paragraph (c)(1)(i) of this section. (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). (ii) The documentation required by paragraph (c)(2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and	F 0622	completed. The DON will report Resident transfers monthly to the QAPI committee including the healthcare information that was sent with the Resident	

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F 0622 SS=E	Continued from page 25 (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. This REQUIREMENT is not met as evidenced by:	F 0622		

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F 0622 SS=E	Continued from page 26 Based on review of clinical records and staff interviews, it was determined that the facility failed to make certain that the necessary resident information was communicated to the receiving health care provider for three of six residents sampled with facility-initiated transfers (Residents R80, R105 and R124). Findings include: Review of the facility policy "Transfer or Discharge, Facility-Initiated" reviewed 1/15/24, and again on 2/3/25, indicated information conveyed to receiving provider, and documentation of transfer to include the resident's care plan goals, advanced directive information, specific instructions for ongoing care, resident representative information, and all information necessary to meet the resident's specific needs at the receiving facility. Review of the clinical record indicated Resident R80 was admitted to the facility on 2/3/24.	F 0622		

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F 0622 SS=E	Continued from page 27 Review of Resident R80's Minimum Data Set (MDS - a periodic assessment of care needs) dated 1/13/25, indicated diagnosis of hypertension (high blood pressure), hyperlipidemia (high fat in the blood) and aphasia (loss of ability to understand or express speech). Review of Resident R80's clinical record revealed that the resident was transferred to the hospital on 1/3/25. Review of Resident R80's clinical record revealed no documented evidence that the facility had communicated specific information to the receiving health care provider for the resident ' s transfer, which included the resident's care plan goals, advanced directive information, specific instructions for ongoing care, resident representative information, and all information necessary to meet the resident's specific needs at the receiving facility. Review of the clinical record indicated Resident R105 was admitted to the facility on 1/2/25.	F 0622		

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F 0622 SS=E	Continued from page 28 Review of Resident R105's Minimum Data Set (MDS - a periodic assessment of care needs) dated 1/9/25, indicated diagnoses of anxiety (intense, excessive, and persistent worry and fear about everyday situations), bipolar (a disorder associated with episodes of mood swings ranging from depressive lows to manic highs), and depression. Review of Resident R105's clinical record revealed that the resident was transferred to the hospital on 1/29/25. Review of Resident R105's clinical record revealed no documented evidence that the facility had communicated specific information to the receiving health care provider for the residents transfer, which included the resident's care plan goals, advanced directive information, specific instructions for ongoing care, resident representative information, and all information necessary to meet the resident's specific needs at the receiving facility.	F 0622		

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F 0622 SS=E	Continued from page 29 Review of the clinical record indicated Resident R124 was admitted to the facility on 7/8/21. Review of Resident R124's MDS dated 11/5/24, indicated diagnoses of high blood pressure, stroke (damage to the brain from an interruption of blood supply), and hemiplegia (paralysis of one side of the body). Review of Resident 124's clinical record revealed that the resident was transferred to the hospital on 9/27/24. Review of Resident R124's clinical record revealed no documented evidence that the facility had communicated specific information to the receiving health care provider for the residents transfer, which included the resident's care plan goals, advanced directive information, specific instructions for ongoing care, resident representative information, and all information necessary to meet the resident's specific needs at the receiving facility.	F 0622		

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F 0622 SS=E	Continued from page 30 Interview on 2/7/25, at 9:33 a.m. the Director of Nursing confirmed that the facility failed to make certain that the necessary resident information was communicated to the receiving health care provider for three of six residents sampled with facility-initiated transfers (Residents R80, R105 and R124). 28 Pa. Code: 201.14(a) Responsibility of licensee. 28 Pa. Code: 201.18(a)(b)(3) Management. 28 Pa. Code: 201.29(b)(d)(j) Resident rights. 28 Pa. Code: 211.12 (d)(1)(3)(5) Nursing services.	F 0622		
F 0641 SS=E		F 0641		

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F 0641 SS=E	Continued from page 31 483.20(g) Accuracy of Assessments §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by:	F 0641	Residents R90, R117, R164 experienced no negative affects of the deficient practice. Resident R64 no longer resides in the facility. RNAC will educate the Social Worders on proper completion of BIMS Assessment per the RAI guidelines RNAC will educate the Dietitian and CDM on how to determine significant weight loss, how to determine when a significant weight loss occurs, and when to code if a weight loss is physician prescribed per RAI guidelines. The RNAC will audit all new MDS assessments weekly for one month, and then 12 MDS Assessments weekly for one month to ensure accuracy of the MDS. Audits and education will be submitted to the QAPI Committee for review and approval.	Completion Date: **03/17/2025** Status: **APPROVED** Date: **02/26/2025**

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CORNER VIEW NURSING AND REHABILITATION CENTER STATE LICENSE NUMBER: **060402**	**6655 FRANKSTOWN AVENUE PITTSBURGH, PA 15206**

(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=E	Continued from page 32 Based on review of facility policy, clinical records and staff interviews it was determined that the facility failed to make certain that resident assessments were accurate for four of 12 residents (Residents R51, R90, R117, and R164). Findings include: The Resident Assessment Instrument (RAI) User's Manual, which gives instructions for completing Minimum Data Set (MDS) assessments (periodic assessments of resident care needs), dated October 2024, indicated that Section C: Cognitive Patterns, Question C0100 "Should Brief Interview for Mental Status Be Conducted?" (BIMS) should be coded as "0" if the resident is rarely/never understood, and that it should be coded "1", and the BIMS assessment should be completed if the resident is at least sometimes understood. Further review of the RAI indicated under "Coding Tips" rules for stopping the BIMS before it is	F 0641		

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F 0641 SS=E	Continued from page 33 complete: 1. All responses up to this point have been nonsensical (making no sense), 2. there has been no verbal or written response to any of the questions up to this point, or 3. there has been no verbal or written response to some questions up to this point and for all others, the resident has given a nonsensical response. The remaining questions would be filled out with a dash (-). The Resident Assessment Instrument (RAI) User's Manual, which gives instructions for completing Minimum Data Set (MDS) assessments (periodic assessments of resident care needs), dated October 2024, indicated that Section K: Swallowing/Nutrition Status, Question K0300, Weight loss, Code 1, yes on physician-prescribed weight-loss regimen: if the resident has experienced a weight loss of 5% or more in the past 30 days or 10% or more in the last 180 days, and the weight loss was planned and pursuant to a physician's	F 0641		

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F 0641 SS=E	Continued from page 34 order. In cases where a resident has a weight loss of 5% or more in 30 days or 10% or more in 180 days as a result of any physician ordered diet plan or expected weight loss due to loss of fluid with physician orders for diuretics, K0300 can be coded as 1. Review of the admission record indicated Resident R51 was admitted to the facility on 1/7/21. Review of Resident R51's MDS dated 12/7/24, indicated the diagnoses of anxiety (repeated episodes of sudden feelings of intense anxiety and fear or terror), schizophrenia (is a mental disorder characterized by disruptions in thought processes, perceptions, emotional responsiveness and social interactions), and depression (mood disorder that causes persistent feelings of sadness and loss of interest). Section C- Cognitive Patterns, Question C0100 indicated that Resident R51 should receive a BIMS interview. Section C had dashes entered for the remainder of the interview questions.	F 0641		

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F 0641 SS=E	Continued from page 35 Interview on 2/6/25, at 9:06 a.m. Director of Social Services Employee E8 confirmed that the facility failed to certain that Resident R51 MDS assessment was accurate. Review of the admission record indicated Resident R90 was admitted to the facility on 2/13/23. Review of Resident R90's MDS dated 12/17/24, indicated the diagnoses of high blood pressure, arthritis, and osteoporosis (a condition in which bones become weak and brittle). Section B: Hearing, Speech, and Vision, Question B0700 indicated that Resident R90 understands and can be understood. Section C: Cognitive Patterns, Question C0100 indicated that Resident R90 should receive a BIMS interview. Section C had dashes entered for the remainder of the interview questions. Review of the admission record indicated Resident R117 was admitted to the facility on 6/9/23. Review of Resident R117's MDS dated 12/2/24,	F 0641		

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F 0641 SS=E	Continued from page 36 indicated the diagnosis of hypertension (high blood pressure), diabetes (high sugar in the blood) and hyperlipidemia (high fat in the blood). Section B: Hearing, Speech, and Vision, Question B0700 indicated that Resident R117 usually understood and usually understands. Section C: Cognitive Patterns, Question C0100 indicated that Resident R117 should receive a BIMS interview. Section C had dashes entered for the remainder of the interview questions. Interview on 02/06/25, at 8:54 a.m. with Director of Social Services Employee E8 indicated "I do not assess, as an example, when they are sleeping. I don't fill it in. Should I be doing it another way? " Review of admission record indicated that Resident R164 was admitted to the facility 12/27/24. Review of Resident R164's MDS dated 1/8/25, indicated the diagnoses necrotizing fasciitis (serious bacterial infection that results in the death of the body's soft tissue), high blood pressure, and	F 0641		

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F 0641 SS=E	Continued from page 37 protein-calorie malnutrition. Section K, Question 0200, Height and Weight, indicate that a Height of 72 inches, and weight of 133 pounds; Question K0300, Weight loss, was coded "1. Yes, on physician-prescribed weight-loss regimen". Review of clinical record indicated that Resident R164 weight as documented on 12/28/24, was 132.8 pounds. No additional weights were available for comparison based on criteria from RAI manual. Review of clinical physician progress notes failed to indicate documentation that Resident R164 was on a physician-prescribed weight-loss regimen. Review of clinical nutrition progress notes failed to indicate documentation that Resident R164 was on a physician-prescribed weight-loss regimen. During an interview on 2/5/25, at 1:50 p.m., Registered Dietitian (RD) Employee E21 revealed that Resident R164 did not have significant weight loss and was not on a physician-prescribed	F 0641		

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F 0641 SS=E	Continued from page 38 weight-lose regimen. RD Employee E21 revealed that MDS information was entered in error. During an interview on 2/5/25, at 3:00 p.m., Registered Nurse Assessment Coordinator (RNAC) Employee E22 confirmed that Section K, Question 0300, Weight loss was entered in error. Interview on 2/6/25, at 3:00 p.m. the Vice President of Clinical Services Employee E9 confirmed the facility failed to make certain that resident assessments were accurate for four of 12 residents (Residents R64, R90, R117, and R164). 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 211.5(f) Clinical Records 28 Pa. Code 211.12(d)(1)(5) Nursing services.	F 0641		

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F 0641 SS=E	Continued from page 39	F 0641		
F 0658 SS=D	483.21(b)(3)(i) Services Provided Meet Professional Standards §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by:	F 0658	Resident R 24 no longer resides at the facility. Employees E1, E2, and E5 were re-educated by the Director of Nursing (DON) on ensuring documentation is entered timely. A look back of 7 days of progress notes on all falls will be conducted by the Director of Nursing/ designee with any corrective action upon discovery. DON/ designee will re-educate all licensed nurses on the importance of timely documentation with each risk management. DON/designee will monitor progress notes 5x per week x2 weeks and 3x per week x2 weeks to ensure notes are put in timely after falls and risk management is complete and accurate.	Completion Date: **03/17/2025** Status: **APPROVED** Date: **02/26/2025**

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F 0658 SS=D	Continued from page 40 Based on review of facility policies, and clinical records, facility documents, as well as staff interviews, it was determined that the facility failed to ensure documentation was timely entered for a resident after an unwitnessed fall occurred for one of three residents (Resident R24). Findings include: Review of the facility policy "Charting and Documentation" reviewed 1/15/24, indicated all services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident ' s medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care. Review of the facility policy "Change in a Resident's Condition or Status" last reviewed 1/15/24, indicated the nurse will record in the resident's	F 0658		

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F 0658 SS=D	Continued from page 41 medical record information relative to changes in the resident's medical/mental condition or status. Review of Residents R24's admission record indicated she was admitted on 11/2/18, and readmitted 1/19/24. Review of Residents R24's Minimum Data Set (MDS - a periodic assessment of care needs) dated 12/11/24, indicated diagnoses of diabetes (a long-term condition in which the body has trouble controlling blood sugar and using it for energy), renal insufficiency (condition where the kidneys lose the ability to remove waste and balance fluids), and dementia (a decline in cognitive functions such as memory, reasoning, and communication, significantly affecting daily life). Review of Resident R24's incident report dated 1/28/25, at 6:00 p.m. completed by Registered Nurse, Employee E1 indicated Resident R24 had an unwitnessed fall.	F 0658		

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F 0658 SS=D	Continued from page 42 Review of a late entry progress note entered by RN, Employee E1 on 1/29/25, at 5:51 a.m. effective 1/28/25, at 6:00 p.m. stated she was called to unit due the resident falling on floor. The nurse on the unit stated she was turned on her side for comfort to poop and rolled onto floor by accident. "Resident denied pain, dizziness or injury. Denies hitting anything upon falling. Vitals stable within normal limits. Care plan to continue." The note was entered after the resident's time of death was called at 5:41 a.m. Review of a late entry progress note entered by Licensed Practical Nurse, Employee E2 on 1/29/25, at 9:55 a.m. effective 1/29/25, at 9:39 a.m. stated this nurse was sitting at nurses' station when I heard someone yelling for help. Nurse Aide went in room, turned around and stated, "resident is on the floor." This nurse went room and found resident laying on her left side parallel to left of bed. 3-11 Supervisor made aware. The note was entered after the resident's time of death was called at 5:41 a.m.	F 0658		

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F 0658 SS=D	Continued from page 43 Review of a late entry progress note entered by RN, Employee E1 on 1/29/25, at 9:41 a.m. effective 1/28/25, at 6:00 p.m. stated RN called to floor by unit nurse for a report of resident falling onto floor. When RN arrived, resident was on the floor being assisted by two nurse aides with a hoyer lift back to bed. Fall was unwitnessed by staff. The note was entered after the resident's time of death was called at 5:41 a.m. Review of a late entry progress note entered by LPN, Employee E2 on 1/29/25, at 9:58 a.m. effective 1/29/25, at 9:56 a.m. stated "This nurse went to check on resident before leaving for the night. Resident was alert and verbal. Resident denied any pain or discomfort." The note was entered after the resident's time of death was called at 5:41 a.m. Review of a late entry progress note entered by LPN, Employee E5 on 1/30/25, at 7:03 a.m. effective 1/29/25, at 6:51 a.m. stated "Resident is alert and oriented, denies any pain or discomfort.	F 0658		

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F 0658 SS=D	Continued from page 44 Resident refused vital signs informed resident vital would be done in the morning. Observed resident three times throughout the night. In the morning found resident absent of all signs." The note was entered after the resident's time of death was called at 5:41 a.m. During an interview on 2/4/25, at 10:11 a.m. RN, Employee E1 stated if a resident falls, a nurse must complete an assessment, obtain vitals, and document right away in risk management and progress notes. RN, Employee E1 confirmed she failed to ensure documentation was timely entered for Resident R24 after an unwitnessed fall occurred. During an interview on 2/4/25, at 10:50 a.m. LPN, Employee E2 stated she left the facility around 11:00 p.m. on 1/28/25, and was made aware Resident R24 ceased to breathe on the morning of 1/29/25. LPN, Employee E2 confirmed she failed to ensure documentation was timely entered for Resident R24 after an unwitnessed fall occurred.	F 0658		

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F 0658 SS=D	Continued from page 45 During an interview on 2/4/25, at 11:33 a.m. the Nursing Home Administrator confirmed the facility failed to ensure documentation was timely entered for a resident after an unwitnessed fall occurred for one of three residents (Resident R24). 28 Pa. Code 211.12(d)(1)(3)(5) Nursing Services.	F 0658		
F 0684 SS=D		F 0684		

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F 0684 SS=D	Continued from page 46 483.25 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	R134 and R368 did not experience a negative outcome. Resident's that require sliding scale insulin will have results reviewed from last week to present to determine if resident was noted with a hyperglycemic episode and if resident was assessed and physician was notified. Nursing notes will be reviewed for 1 week to present for any new skin conditions and proper documentation is in place with measurements and treatment orders. Education to be performed with licensed nursing staff on importance of MD notification of hypo/hyperglycemia and assessment as well as new or change in skin condition with proper documentation and treatment order. Audits on short acting insulin with a sliding scale for above or below will be conducted 3x a week times 2 weeks, 2x a week x2 weeks and 1x a	Completion Date: **03/17/2025** Status: **APPROVED** Date: **02/26/2025**

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F 0684 SS=D	Continued from page 47	F 0684	week x2 weeks to ensure orders followed and physician notification are met. Audit new skin conditions to ensure measurements and orders are documented timely by review of nursing notes and orders. 3x a week time 2 weeks, 2x a week times 2 weeks, and 1x week times 2 weeks.	

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F 0684 SS=D	Continued from page 48 Based on a review of facility policy, clinical records, and staff interviews, it was determined that the facility failed to assess, document, and notify physicians of an abnormal Capillary Blood Glucose (CBG) levels for one of four residents reviewed (Resident R134), and failed to appropriately respond to a resident's change in condition for one of four residents (Resident R368). Findings include: Review of facility policy "Obtaining a Fingerstick Glucose Level" reviewed 1/15/24, indicated that the procedure is to obtain a blood sample to determine the resident's blood glucose level. The person performing this procedure should record the following information in the resident's medical record: 1. The date and time the procedure was performed. 2. The name and title of the individual(s) who performed the procedure. 3. All assessment data obtained during the procedure.	F 0684		

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F 0684 SS=D	Continued from page 49 4. If the resident refused the procedure, the reason(s) why and the intervention taken. 5. The blood sugar result. 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 mediation dosage), etc. 6. The signature and title of the person recording the data. 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	F 0684		

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F 0684 SS=D	Continued from page 50 responding to insulin, too much blood sugar stays in 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	F 0684		

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F 0684 SS=D	Continued from page 51 wounds. Review of the facility policy "Skin Integrity-Skin Tears" reviewed 1/15/24, indicated it is the policy of the facility to provide proper treatment and care to maintain skin integrity. Licensed nurses will conduct skin assessments in accordance with facility policy. When a skin tear is discovered, the attending physician will be notified. Review of the facility policy "Change in a Resident's Condition or Status" last reviewed 1/15/24, indicated the nurse will record in the resident's medical record information relative to changes in the resident's medical/mental condition or status. Review of the clinical record indicated Resident R134 was admitted to the facility on 12/13/24. Review of the Minimum Data Set (MDS - periodic assessment of resident care needs) dated 1/8/25, indicated diagnoses of chronic obstructive pulmonary disease, chronic kidney disease, and	F 0684		

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F 0684 SS=D	Continued from page 52 diabetes mellitus (metabolic disorder in which the body has high sugar levels for prolonged periods of time). Review of Resident R134 physician order dated 12/13/24, indicated to administer Humalog KwikPen Subcutaneous Solution Peninjector 100 unit/ml [milliliter] (Insulin Lispro [a short acting, manmade version of human insulin]) Inject as per sliding scale: if 70 - 140 = 0; 141 - 180 = 1; 181 - 220 = 2; 221 - 260 = 3; 261 - 300 = 4; 301 - 340 = 5; 341 - 999 = 6 and call MD, subcutaneously before meals. Review of Resident R134's care plan dated 1/30/35, indicated Diabetes medication as order by doctor. Monitor/document for side effects and effectiveness. Monitor/document/report as needed any signs or symptoms of hyperglycemia. Review of Resident R134's eMAR (electronic Medication Administration Record) revealed that the resident's CBG's were as follows:	F 0684		

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F 0684 SS=D	Continued from page 53 On 1/28/25, at 8:29 p.m., the CBG was noted to be 500. Review of Resident R134's eMAR and clinical progress notes indicated the resident was not assessed for hyperglycemia, the blood glucose was not monitored for effectiveness of treatment, staff failed to follow interventions of the care plan, and the physician was not notified of abnormal results on the above listed date. During an interview on 2/6/25, at 10:00 a.m., the Vice President of Clinical Services Employee E9 confirmed that the facility failed to assess, document, and notify physicians of an abnormal Capillary Blood Glucose (CBG) levels for one of four residents reviewed (Resident R134) Review of the clinical record indicated Resident R368 was admitted to the facility on 11/13/24. Review of the Minimum Data Set (MDS - periodic	F 0684		

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F 0684 SS=D	Continued from page 54 assessment of resident care needs) dated 11/20/24, included diagnoses of high blood pressure, lymphedema (condition that results in swelling of the leg or arm), and an acquired absence of left leg below the knee. Review of Resident R368's progress note dated 11/29/24, indicated the resident went out for a family visit on Thanksgiving and fell at a family member's house. An open area to the right knee area was observed. Review of the clinical record failed to indicate an assessment of Resident R368's right knee wound or that the doctor was notified. Review of Resident R368's "Nursing-Weekly Skin Evaluation" dated 12/5/24, indicated the resident had a left lower leg skin tear. The facility failed to identify the correct anatomical position of the resident's right knee wound and provide a description including measurements. Review of Resident R368's clinical record revealed a progress note dated 12/11/24, that indicated the	F 0684		

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F 0684 SS=D	Continued from page 55 resident was seen for follow up and management of the resident's wounds. It was indicated Certified Physician Assistant, Employee E16 spoke with the resident's family member who was concerned about the resident's knee wound from when he fell on Thanksgiving. The resident had a full thickness trauma wound that measured 3 centimeters (cm) x 3 cm x 0.1 cm. It was indicated there was a scant amount of drainage noted and the wound bed was covered with 76-100% slough. Review of Resident R368's physician order dated 12/12/24, indicated to cleanse the right knee wound with normal saline (solution used to cleanse and irrigate wounds), apply medi honey (wound and burn gel that assists in wound healing and has antibacterial and bacterial resistant properties), and cover with a dry dressing every day shift. The facility failed to obtain a physician order for Resident R368's right knee wound for a total of 14 days. Review of Resident R368's clinical record on 2/5/25, at 10:18 a.m. failed to include an assessment	F 0684		

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F 0684 SS=D	Continued from page 56 of Resident R368's right knee wound that included a description and measurement of Resident R368's right knee wound from 11/29/24, through 12/10/24. A total of 13 days. During an interview on 2/5/25, at 11:26 a.m. the Vice President of Clinical Services, Employee E9 confirmed the facility to timely notify a physician, assess and obtain orders for Resident R368's right knee wound. 28 Pa. Code: 201.18(b)(1) Management. 28 Pa. Code: 201.29(a) Resident rights. 28 Pa. Code: 201.10(c)(d) Resident care policies. 28 Pa. Code: 211.12(d)(1)(3)(5) Nursing services.	F 0684		
F 0688 SS=E		F 0688		

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F 0688 SS=E	Continued from page 57 483.25(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	Resident # 50 no longer resides at the facility. Resident #s 15, 22, 43, 45 were assessed by the DON/Designee with no negative findings. Resident #15s left palm guard was placed on the resident. Heel lift boots were applied and bilateral wedges and left knee extension splint placed on resident # 22 per physician orders. Resident #43 was assessed by therapy for the need of a splint on 1/9/25. Bilateral hand splints and bilateral elbow splints were placed on resident # 45. All residents with orders for splints, wedges, and heel lift boots have the potential to be affected. The DON/Designee will audit all residents with orders for splints,	Completion Date: **03/17/2025** Status: **APPROVED** Date: **02/26/2025**

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F 0688 SS=E	Continued from page 58	F 0688	wedges, and heel lift boots to ensure they are applied as ordered. Findings will be corrected at the time of the initial audit. The DON/Designee will educate licensed nurse and CNA's on applying as ordered The DON/Designee will audit all residents with orders for splints, wedges, and heel lift boots weekly x 4 weeks to ensure they are applied as ordered. Audits and education will be submitted to the QAPI Committee for review and approval.	

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F 0688 SS=E	Continued from page 59 Based on facility policy, observation, clinical record review, and staff interview, it was determined that the facility failed to provide treatment and services to prevent further decrease in range of motion for five of seven residents (Residents R15, R22, R43, R45, and R50). Findings include: Review of the facility policy "Assistive Devices and Equipment" dated 2/3/25, indicated the facility maintains and supervised the use of assistive devices and equipment for residents. Staff are trained and demonstrate competency on the use of devices and equipment prior to assisting or supervising residents. Review of the admission record indicated R15 was admitted to the facility on 10/31/24. Review of Resident R15's Minimum Data Set (MDS - a periodic assessment of care needs) dated 5/31/24, indicated the diagnoses of stroke (damage to the brain from an interruption of blood supply),	F 0688		

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F 0688 SS=E	Continued from page 60 anemia (the blood doesn't have enough healthy red blood cells), and atrial fibrillation (irregular heart rhythm). Review of Resident R15's physician order dated 12/20/24, indicated wear left palm guard (splint that positions the fingers away from the palm to protect the skin from moisture, pressure, and nail puncture) with finger separators three to four hours daily during daylight shift as tolerated by the resident. Remove for care and check skin integrity before and after putting on and taking off palm guard. Review of Resident R15's care plan dated 2/3/25, indicated wear left palm guard with finger separators three to four hours daily during daylight shift as tolerated by the resident. Remove for care and check skin integrity before and after putting on and taking off palm guard. Observations on 2/3/25, at 9:00 a.m., 2/4/25, at 9:15 a.m., and 2/5/25, at 11:12 a.m., Resident R15 was observed in room with left hand contracture (an	F 0688		

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F 0688 SS=E	Continued from page 61 abnormal thickening of tissues in the palm of the hand that over time can cause the fingers to curl in toward the palm) without the palm guard in place as ordered. Interview on 2/5/25, at 11:12 a.m. Licensed Practical Nurse (LPN) Employee E10 confirmed Resident R15's left hand was contracted and that the brace was not present over the past three days. Review of the admission record indicated R22 was admitted to the facility on 7/29/20. Review of Resident R22's MDS dated 11/2/24, indicated the diagnoses of Non-Alzheimer's Dementia (dementia caused by other diseases with symptoms forgetfulness, limited social skills, and impaired thinking abilities that interfere with daily functioning), Bipolar (a disorder associated with episodes of mood swings ranging from depressive lows to manic highs), and high blood pressure. Review of Resident R22's physician order dated	F 0688		

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F 0688 SS=E	Continued from page 62 5/11/23, indicated resident is to use bilateral (both sides) wedges at lateral sides of knees and bilateral heel lift boots at all times when in bed except for during care. Review of Resident R22's physician order dated 10/4/23, indicated resident to use left knee extension splint (for gradual extension of nonfixed knee contracture) three to four hours daily during daylight shift, may remove for care. Review of Resident R22's care plan dated 2/3/25, indicated resident is to use bilateral wedges at lateral sides of knees and bilateral heel lift boots at all times when in bed except for during care, and resident to use left knee extension splint three to four hours daily during daylight shift, may remove for care. Observations on 2/3/25, at 9:00 a.m., 2/4/25, at 9:15 a.m., and 2/5/25, at 11:12 a.m., Resident R22 was observed in bed, without bilateral wedges at lateral sides of knees and bilateral heel lift boots, and without left knee extension splint. Equipment	F 0688		

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F 0688 SS=E	Continued from page 63 noted on the top of the wardrobe closet. Interview on 2/5/25, at 11:15 a.m. Nurse Aide (NA) Employee E11 indicated there is only one restorative staff for the entire facility with five separate floors, and restorative isn't here every day, and frequently gets pulled to care assignments. The floor aides do not apply the splints. "I know he hasn't had them on for the last three days". Review of the admission record indicated R43 was admitted to the facility on 6/13/23. Review of Resident R43's MDS dated 1/15/25, indicated the diagnoses of schizophrenia (a disorder that affects a person's ability to think, feel, and behave clearly), seizure disorder (a person experiences abnormal behaviors, symptoms and sensations, sometimes including loss of consciousness), and anemia. Review of Resident R43's care plan dated 1/23/25, indicated resident is dependent for all activities of	F 0688		

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F 0688 SS=E	Continued from page 64 daily living and care needs. Observations on 2/4/25, at 9:15 a.m., and 2/5/25, at 11:12 a.m., Resident R22 was observed in bed, with left hand visibly contracted. Interview on 2/5/25, at 11:20 a.m. LPN Employee E10 confirmed Resident R22 had a left-hand contracture and that he did not have a splint ordered as required to protect his palm. Review of the admission record indicated R45 was admitted to the facility on 1/10/19. Review of Resident R45's MDS dated 11/4/24, indicated the diagnoses of cerebral palsy (a congenital disorder of movement, muscle tone, or posture caused by abnormal brain development), high blood pressure, and quadriplegia (a symptom of paralysis that affects all of a person's limbs and body from the neck down). Review of Resident R45's current physician orders	F 0688		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395423	A. BLDG: __00_____ B. WING: _____	02/07/2025

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F 0688 SS=E	Continued from page 65 indicated resident to wear right elbow extension splint and left-hand splint at the same time for two to four hours during the daylight shift alternating with left elbow and right-hand splints for two to four hours during the daylight shift as tolerated by resident. Off during meals. Review of Resident R45's care plan dated 11/19/24, indicated resident to wear right elbow extension splint and left-hand splint at the same time for two to four hours during the daylight shift alternating with left elbow and right-hand splints for two to four hours during the daylight shift as tolerated by resident. Off during meals. Observations on 2/3/25, at 9:00 a.m., and 2/5/25, at 11:12 a.m., Resident R45 was observed in bed, without his right elbow extension splint and left-hand splint, or his left elbow and right-hand splints. Interview on 2/5/25, at 11:30 a.m. Nurse Aide (NA) Employee E11 confirmed Resident R45 has not been wearing his splints as ordered, and the	F 0688		

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F 0688 SS=E	Continued from page 66 floor aides do not apply the assistive devices. Review of the admission record indicated R50 was admitted to the facility on 8/3/23, and readmitted 11/8/24. Review of Resident R50's MDS dated 1/22/25, indicated the diagnoses of acquired absence of right leg below knee, contracture, and muscle weakness. Review of Resident R50's current physician orders dated 12/4/24, indicated resident to wear left knee extension splint when in bed for 3-4 hours during the daylight shift as tolerated by resident. Review of Resident R50's care plan dated 2/3/25, indicated resident to wear left knee extension splint when in bed 3-4 hours daily during the daylight shift as tolerated by the resident. The facility failed to timely implement a care plan for Resident R50's splint. A total of 61 days since the resident was ordered the left knee extension splint.	F 0688		

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F 0688 SS=E	Continued from page 67 During an observation and interview on 2/3/25, at 9:55 a.m., Resident R50 was observed in bed without his left knee extension splint. Resident R50 indicated the facility does nothing for his good leg. During an observation and interview on 2/3/25, at 12:49 p.m. Resident R50 was observed again without his left knee extension splint. He indicated he is supposed to have an arm brace too. Resident R50 stated he only had his knee brace on about one to two times since he's been in the facility. Resident R50 indicated no one has offered him his left knee extension splint and stated he is unsure where it even is. During an interview on 2/3/25, at 12:56 p.m. Licensed Practical Nurse, Employee E17 was asked if he seen Resident R50's left knee extension splint and he stated "I don't know if I seen it the last few days, honestly I haven't looked." LPN, Employee E17 confirmed the facility failed to provide Resident R50's left knee extension splint as ordered.	F 0688		

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F 0688 SS=E	Continued from page 68 During an observation on 2/5/25, at 11:42 a.m. Resident R50 was observed lying in bed without his left knee extension splint intact. He indicated he is unsure if he has one. During an interview on 2/5/25, at 11:51 a.m. LPN, Employee E19 confirmed Resident R50's knee splint was not available and she was unsure where it was. Interview on 2/5/25, at 11:50 a.m. Vice President of Clinical Employee E9 indicated the restorative program is broken and confirmed the facility failed to provide treatment and services to prevent further decrease in range of motion for five of seven residents (Residents R15, R22, R43, R45, and R50). 28 Pa. Code: 201.29(j) Resident rights. 28 Pa. Code: 211.10(c)(d) Resident care policies. 28 Pa. Code: 211.12(d)(1)(2)(3)(5) Nursing services.	F 0688		

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F 0688 SS=E	Continued from page 69	F 0688		
F 0692 SS=D		F 0692		

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 0692 SS=D	Continued from page 70 483.25(g)(1)-(3) Nutrition/Hydration Status Maintenance §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by:	F 0692	Resident # 121 no longer resides at the facility. All residents with significant weight loss have the potential to be affected. The Registered Dietician will be educated on the facility policy for weight assessment and intervention by DON/Designee. The DON/Designee will audit weights obtained in the last 30 days to ensure all residents with significant weight loss are assessed by the Registered Dietician and ensure that the care plans are updated for residents with significant weight loss. The DON/Designee will audit weights weekly x 4 weeks to ensure residents with a significant weight loss are assessed by the Registered Dietician and care plans are updated. Results of the audits will be forwarded to the center QAPI	Completion Date: **03/17/2025** Status: **APPROVED** Date: **02/26/2025**

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 0692 SS=D	Continued from page 71	F 0692	committee for review and recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0692 SS=D	Continued from page 72 Based on review of facility policies, clinical records, and staff interviews, it was determined that the facility failed to make certain that weight loss was identified and addressed in a timely manner and failed to update an individualized care plan to address the resident's specific nutritional concerns and preferences for one of seven (Resident R121) records reviewed. Findings include: Review of facility policy "Nutritional Assessment", dated 1/15/24, indicated as part of the comprehensive assessment, a nutritional assessment, including current nutritional status and risk factors for impaired nutrition , shall be conducted for each resident. Individualized care plans shall address, to the extent possible: a. The identified causes of impaired nutrition; b. The resident's personal preferences; c. Goals and benchmarks for improvement; d. Time frames and parameters for monitoring and reassessment.	F 0692		

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F 0692 SS=D	Continued from page 73 The Resident Assessment Instrument (RAI) User's Manual, which gives instructions for completing Minimum Data Set (MDS) assessments (mandated assessments of a resident's abilities and care needs), dated October 2024, indicated the following instructions: - Section K0300: significant weight loss is defined as 5% weight loss or more in 30 days or 10% weight loss or more in 180 days GUIDANCE §483.25(g) Significant weight loss is defined as: 5% or greater in one month 7.5% or greater in three months 10% or greater in six months Review of the clinical record revealed Resident R121 was originally admitted to the facility on 12/6/24, with readmission date of 12/31/24. Review of Resident R121's Minimum Data Set (MDS - a periodic assessment of care needs) dated	F 0692		

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 0692 SS=D	Continued from page 74 1/7/25, indicated diagnoses cerebral infarction (also known as an ischemic stroke, occurs when blood flow to the brain is disrupted due to issues with the arteries that supply it), rheumatoid arthritis (chronic inflammatory disorder that affects your joints and other body systems), and, protein-calorie malnutrition. Review of Resident R121's MDS dated 1/7/25, Section K - Swallowing/Nutritional Status, Question K0300 Weight Loss was coded "2" indicating a loss of 5% or more in the last month or loss of 10% or more in last 6 months and not on a physician-prescribed weight-loss regimen. Review of Resident R121's "Vitals - Weights" revealed the following documented weights: 12/31/2024 - 193.8 lbs (pounds) = 17.5 % weight loss (41.2 lbs) within 1 month 12/6/2024 - 235.0 lbs 12/6/2024 - 230.0 lbs Review of clinical nutrition/dietary note dated	F 0692		

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F 0692 SS=D	Continued from page 75 1/9/25, referenced to coordinate with MDS ARD (Assessment Reference Date) 1/7/25, failed to indicate Resident R121's weight history, and therefore failing to identify and assess resident's significant loss in weight. Review of Resident R121's nutritional care plan initiated 1/30/25, failed to identify significant weight loss as a nutritional problem, and failed to have updated goals and interventions to monitor, reassess, and address resident's specific nutritional concerns. During an interview on 2/7/25, at 10:30 a.m., Registered Dietitian (RD) Employee E21 stated that she did not document or address Resident R121's significant weight loss in her clinical notes or care plan, and confirmed that the facility failed to make certain that weight loss was identified and addressed in a timely manner and failed to update an individualized care plan to address the resident's specific nutritional concerns and preferences for one of seven (Resident R121) records reviewed.	F 0692		

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F 0692 SS=D	Continued from page 76 28 Pa. Code: 201.18(b)(1)(e)(1) Management. 28 Pa. Code: 211.12(d)(1)(3)(5) Nursing services.	F 0692		
F 0693 SS=D		F 0693		

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F 0693 SS=D	Continued from page 77 483.25(g)(4)(5) Tube Feeding Mgmt/Restore Eating Skills §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by:	F 0693	Enteral nutrition order for resident # 269 will be updated by the Registered Dietitian to include the mechanism of administration and total volume. Resident #121 no longer resides at the facility. All residents receiving enteral nutrition have the potential to be affected. The DON/Designee will audit all residents with enteral feed orders to ensure orders contain the total volume and mechanism of administration. The Registered Dietician and Licenses nurses will be educated on the facility policy for enteral nutrition by the DON/Designee. The DON/Designee will audit all residents with enteral feed orders weekly x 4 weeks to ensure orders contain total volume, mechanism of administration and care plans are updated	Completion Date: **03/17/2025** Status: **APPROVED** Date: **02/26/2025**

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F 0693 SS=D	Continued from page 78	F 0693	Results of the audits will be forwarded to the center QAPI committee for review and recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0693 SS=D	Continued from page 79 Based on facility policy, clinical record review and staff interview, it was determined the facility failed to provide appropriate care and services to residents receiving tube feedings for two of five residents reviewed (Residents R121, and R269). Findings Include: Review of facility policy "Enteral Nutrition" dated 1/15/24, indicated adequate nutrition support through enteral nutrition is provided to residents as ordered. The Nurse confirms that orders for enteral nutrition are complete. Complete orders include: - The enteral nutrition product; - The specific enteral access device (nasogastric, gastric, jejunostomy tube, etc.); - Administration method (continuous, bolus, intermittent); - Volume and rate of administration; - The volume/rate goals - Instructions for flushing Review of facility policy "Nutritional Assessment",	F 0693		

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F 0693 SS=D	Continued from page 80 dated 1/15/24, indicated as part of the comprehensive assessment, a nutritional assessment, including current nutritional status and risk factors for impaired nutrition, shall be conducted for each resident. Individualized care plans shall address, to the extent possible: a. The identified causes of impaired nutrition; b. The resident's personal preferences; c. Goals and benchmarks for improvement; d. Time frames and parameters for monitoring and reassessment. Review of the clinical record revealed Resident R121 was originally admitted to the facility on 12/6/24, with readmission date of 12/31/24. Review of Resident R121's Minimum Data Set (MDS - a periodic assessment of care needs) dated 1/7/25, indicated diagnoses cerebral infarction (also known as an ischemic stroke, occurs when blood flow to the brain is disrupted due to issues with the arteries that supply it), rheumatoid arthritis (chronic inflammatory disorder that affects your joints and	F 0693		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0693 SS=D	Continued from page 81 other body systems), and, protein-calorie malnutrition. MDS Section K0520 indicated a feeding tube present. Review of physician order dated 12/31/24, indicated an enteral feed order every shift administer Kate Farms Standard 1.4 via GT (gastrostomy tube) at a rate of 65cc/hr (cubic centimeter per hour) to begin at 1400 (2:00 p.m.), and end at 0600 (6:00 a.m.). Physician order failed to indicate the total volume of Kate Farms 1.4 formula over the 16 hours period of administration, and failed to identify the mechanism for administration (pump or gravity). Review of Resident R121's current care plan initiated 1/2/25, with revision on 1/30/25, failed to include physician ordered care and services appropriate for receiving enteral nutritional support. Review of the clinical record revealed Resident R269 was admitted to the facility on 1/31/25. Review of Resident R269's clinical record indicated	F 0693		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395423	A. BLDG: 00 B. WING:	02/07/2025

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F 0693 SS=D	Continued from page 82 diagnoses on admission to include ischemia of the large intestines (a disorder that develops when blood flow to the colon is partially or completely blocked), high blood pressure, and protein-calorie malnutrition. Review of Resident R269's clinical progress note on 2/3/25, at 10:59 p.m., indicated resident alert and oriented times 3. PEG tube patent and intact. Tolerating enteral feed, meds, and flushes without difficulty. Review of physician order dated 1/31/25, indicated an enteral feed order every shift administer Isosource via PEG (Percutaneous endoscopic gastrostomy tube) at a rate of 55ml/hr (milliliters per hour) to begin at 1400 (2:00 p.m.), and end at 0600 (6:00 a.m.). Physician order failed to indicate the total volume of Isosource formula over the 16 hours period of administration, and failed to identify the mechanism for administration (pump or gravity). During an interview on 2/6/25, at 10:10 a.m., Vice	F 0693		

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F 0693 SS=D	Continued from page 83 President of Clinical Operations Employee E9 confirmed that the facility failed to provide appropriate care and services to residents receiving tube feedings for two of five residents reviewed (Residents R121, and R269). 28 Pa. Code: 201.18(b)(1) Management. 28 Pa. Code: 211.10(c) Resident care policies. 28 Pa. Code: 211.12(d)(1) Nursing services.	F 0693		
F 0695 SS=D		F 0695		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0695 SS=D	Continued from page 84 483.25(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	Resident 122s nasal cannulas were replaced and dated immediately upon discovery by the licensed nurse. Current residents who require oxygen and/or nebulizer treatments have the potential to be affected. An initial audit of residents who require oxygen and/or nebulizer treatments will be conducted by the Director of Nursing/designee to ensure nasal cannulas are dated, care plans reflect need for oxygen and/or nebulizers, and orders are in place for oxygen. Licensed nursing staff will be reeducated on labeling/dating nasal cannulas and nebulizer tubing, implementing care plans for respiratory care, and obtaining MD orders for respiratory care. Audits of 5 residents will be conducted weekly x4 weeks by the Director of Nursing/designee to ensure compliance. Results of the audits will be forwarded to the center QAPI	Completion Date: **03/17/2025** Status: **APPROVED** Date: **02/26/2025**

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F 0695 SS=D	Continued from page 85	F 0695	committee for review and recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0695 SS=D	Continued from page 86 Based on review of facility policy, observations, staff interviews, and clinical record review, it was determined that the facility failed to provide appropriate respiratory care related to oxygen management for one of four residents (Resident R122). Findings include: A review of the facility policy "Respiratory Therapy" last reviewed on 2/3/25, indicates obtain equipment (i.e., oxygen tubing, reservoir, and distilled water) change the oxygen cannula and tubing every seven days or as needed. A review of Resident R122's clinical record indicates an admission date of 6/24/22. A review of R122's Minimum Data Set (MDS-periodic assessment of care needs) dated 12/9/24, indicate the diagnosis of hypertension (high blood pressure), chronic obstructive pulmonary disease (COPD- constriction of airways) and	F 0695		

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F 0695 SS=D	Continued from page 87 anxiety. During an observation on 2/3/25, at 10:19 Resident R122 was in bed, her oxygen was on via nasal canula (thin flexible tube used to deliver oxygen). The oxygen tubing failed to be labeled with a date. During an interview completed on 2/3/25, at 12:03 p.m. Licensed Practical Nurse (LPN) Employee E24 confirmed the oxygen tubing failed to be labeled with a date. A review of Resident R122's physician orders dated 4/8/24, indicate patient is to remain on 2-5 liters high flow oxygen, patient is 02 (oxygen) dependent every shift and failed to include the percentage of oxygen saturation to maintain comfort or the method of oxygen delivery. During an interview completed on 2/7/25, at 12:40 p.m. Registered Nurse (RN) Supervisor Employee E13 confirmed the order failed to include the percentage of oxygen saturation to maintain comfort	F 0695		

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F 0695 SS=D	Continued from page 88 or the method of oxygen delivery and confirmed that the facility failed to provide appropriate respiratory care related to oxygen management for one of four residents (Resident R122). 28 Pa. Code: 211.10(c)(d) Resident care policies. 28 Pa. Code: 211.12(d)(1)(2)(3)(5) Nursing services.	F 0695		
F 0699 SS=D		F 0699		

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F 0699 SS=D	Continued from page 89 483.25(m) Trauma Informed Care §483.25(m) Trauma-informed care The facility must ensure that residents who are trauma survivors receive culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident. This REQUIREMENT is not met as evidenced by:	F 0699	1. Residents R23, R85, and R45 care plan was updated for PTSD including interventions. Residents R23, R85, and R45 has not experienced any negative effects. 2. Initial audit of PTSD care plans were performed. 3. Social Workers will be educated on the need to care plan residents with PTSD and suicidal ideation interventions. 4. Audits of residents who trigger for PTSD are care planned and person centered 3x a week times 2 weeks, 2x a week times 2 weeks, and 1x week times 2 weeks. 5. The monthly reviews will be submitted to the QAPI committee for review and approval.	Completion Date: **03/17/2025** Status: **APPROVED** Date: **02/26/2025**

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F 0699 SS=D	Continued from page 90 Based on clinical record review and staff interview, it was determined that the facility failed to ensure that residents received trauma-informed care to eliminate or mitigate triggers for residents with the diagnosis of Post Traumatic Stress Disorder (PTSD - a mental and behavioral disorder that develops related to a terrifying event) for three of 11 residents reviewed (Resident R23, R45, and R85). Findings include: Review of the facility policy "Trauma Informed Care" dated 2/3/25, indicated the purpose to guide staff in appropriate and compassionate care specific to individuals who have experienced trauma, and post-traumatic stress disorder in the context of the healthcare setting. Caregivers are taught strategies to help eliminate, mitigate or sensitively address a resident's triggers that are person-centered. Review of the clinical record indicated Resident R23 was admitted to facility on 8/15/24, with the diagnosis of anxiety, cerebellar ataxia (affects	F 0699		

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F 0699 SS=D	Continued from page 91 balance gait, and eye movements) and PTSD. Review of Resident R23's care plan dated 1/19/24, indicated the resident has been exposed to a traumatic event related to PTSD diagnosis. The care plan did not include specific triggers. There was no documented evidence the facility identified Resident 23's specific triggers that could re-traumatize the resident or implement measures as to how facility staff could prevent or minimize triggers from occurring. Review of the admission record indicated Resident R45 was admitted to the facility on 1/10/19. Review of Resident R45's MDS dated 11/4/24, indicated the diagnoses of cerebral palsy (a congenital disorder of movement, muscle tone, or posture caused by abnormal brain development), high blood pressure, and quadriplegia (a symptom of paralysis that affects all of a person ' s limbs and body from the neck down), and PTSD.	F 0699		

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F 0699 SS=D	Continued from page 92 Review of Resident R45's care plan dated 2/5/25, indicated resident has psychosocial well-being problem related to relational trauma by maternal abuse. The care plan did not include specific triggers. There was no documented evidence the facility identified Resident 45's specific triggers that could re-traumatize the resident or implement measures as to how facility staff could prevent or minimize triggers from occurring. Review of the clinical record indicated Resident R85 was admitted to facility on 12/3/24. Review of Resident R85's MDS dated 1/4/25, indicated the diagnosis of atrial fibrillation (rapid and irregular heart rhythm), bipolar disorder (mental health condition that causes extreme mood swings), and anxiety. Review of Resident R85's care plan dated 5/5/24,	F 0699		

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F 0699 SS=D	Continued from page 93 indicated the resident has a psychosocial wellbeing problem actual PTSD related to reported history of physical abuse, vehicular accident. There was no documented evidence the facility identified Resident 85's specific triggers that could re-traumatize the resident or implement measures as to how facility staff could prevent or minimize triggers from occurring. Interview with Social Services Director Employee E8, on 2/6/25, at 9:42 a.m. confirmed the facility failed to identify specific triggers, and failed to ensure that residents received trauma-informed care to eliminate or mitigate triggers for residents with the diagnosis of PTSD for three of 11 residents reviewed (Resident R23, R45, and R85). 28 Pa Code 201.24(e)(4) Admission Policy. 28 Pa Code 211.12(a)(d)(3)(5) Nursing Services. 28 Pa. Code 211.16(a) Social Services.	F 0699		

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F 0699 SS=D	Continued from page 94	F 0699		
F 0742 SS=D	483.40(b)(1) Treatment/Srvcs Mental/Psychoscial Concerns §483.40(b) Based on the comprehensive assessment of a resident, the facility must ensure that- §483.40(b)(1) A resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder, receives appropriate treatment and services to correct the assessed problem or to attain the highest practicable mental and psychosocial well-being; This REQUIREMENT is not met as evidenced by:	F 0742	1. Resident R23 has been discharged from the facility and unable to rectify. 2. Social Workers will be educated on the need to care plan residents with PTSD and suicidal ideation interventions by the DON/Designee as well as perform psychosocial assessments. 3. Initial audit will be performed for any resident who trigger for PTSD or suicidal ideations by the Director of Social Services. Audits then will be performed 3x a week times 2 weeks, 2x a week times 2 weeks, 1x a week times 2 weeks. 4. The monthly reviews will be submitted to the QAPI committee for review and approval.	Completion Date: **03/17/2025** Status: **APPROVED** Date: **02/27/2025**

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F 0742 SS=D	Continued from page 95 Based on clinical records and facility policy review, and staff interview, it was determined that the facility failed to ensure that a resident who displayed mental or psychosocial adjustment difficulties received appropriate treatment and services for one of eleven residents (Resident R23). Findings include: Review of the facility policy "Trauma Informed Care" last reviewed 2/3/25, indicated this facility supports a culture of emotional well-being and physical safety for staff, residents and visitors. Caregivers are taught strategies to help eliminate, mitigate or sensitively address a resident ' s triggers. As part of the comprehensive assessment, identify history of trauma or interpersonal violence when possible. Identifying past trauma or adverse experiences may involve record review or the use of screening tools. Review of the Social Services job description indicated it is the responsibility of Social Services to	F 0742		

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F 0742 SS=D	Continued from page 96 ensure that the medically related emotional and social needs of residents are met/maintained on an individual basis. Develop social assessment and care plan, which identifies medically related social and emotional problems and needs with realistic goals and specific actions to be taken. Review of the clinical record indicated Resident R23 was admitted to facility on 8/15/24, with the diagnosis of bipolar disorder (causes extreme mood swings) post-traumatic stress disorder (PTSD - a mental and behavioral disorder that develops related to a terrifying event) and anxiety. Review of the nursing progress notes dated 2/5/25, at 12:18 p.m. physician updated about suicidal ideations which is not new for patient. Social services going to see patient and discuss concerns. Review of nursing progress note dated 2/5/25, at 4:07 p.m., indicated "This writer spoke with social services regarding residents' concerns. Consulted with resident and made aware of how she is feeling	F 0742		

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F 0742 SS=D	Continued from page 97 and her newly increased anxiety. Placed call to physician informing him of current situation. New orders for Haloperidol 5mg PO (by mouth) q (every) 4 (hours) PRN (as needed) for anxiety. Resident informed and educated on medication purpose and uses. Residence expressed appreciation while tearful but able to verbalize when to seek nursing for guidance and medication as ordered. Will follow up with social services. No other issues at this time. Will continue to monitor." During an interview on 2/6/25, at 9:42 a.m. Social Services Director Employee E8, indicated if a resident is expressing suicidal ideation, a psychosocial assessment would be completed and confirmed the assessment was not completed for Resdient R23. Review of Resident R23's care plan on 2/6/25, failed to include interventions for suicidal ideation. During an interview on 2/6/25, at 12:00 p.m. the Registered Nurse (RN) Supervisor Employee E13	F 0742		

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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NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
CORNER VIEW NURSING AND REHABILITATION CENTER	**6655 FRANKSTOWN AVENUE PITTSBURGH, PA 15206**
STATE LICENSE NUMBER: **060402**	

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F 0742 SS=D	Continued from page 98 stated "I called the physician and received the new orders for Haldol, I had social service talk to her"; confirmed the care plan did not have any intervention in place for Resident R23's suicidal ideations and confirmed the facility failed to ensure that a resident who displayed mental or psychosocial adjustment difficulties received appropriate treatment and services for one of eleven residents (Resident R23). 28 Pa. Code 201.18(b)(1) Management. 28 Pa. Code 211.12(d)(3)(5) Nursing services.	F 0742		
F 0744 SS=D		F 0744		

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F 0744 SS=D	Continued from page 99 483.40(b)(3) Treatment/Service for Dementia §483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. This REQUIREMENT is not met as evidenced by:	F 0744	Resident R35s care plan has been updated by nursing to include dementia related services. Current residents with dementia will be reviewed by the Director of Nursing(DON) /designee to ensure their care plans are comprehensive. Reeducation will be provided by the DON to all licensed nursing staff that all residents with dementia must have a care plan for related services. The DON/designee will monitor all new admissions, readmissions, resident's change in condition, and quarterly care plans to ensure care plans are developed and implemented for each resident to include dementia related services daily for 3 weeks, then 3 times a week for 3 weeks, and then randomly thereafter.	Completion Date: **03/17/2025** Status: **APPROVED** Date: **02/26/2025**

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F 0744 SS=D	Continued from page 100 Based on clinical record review and staff interview, it was determined that the facility failed to develop and implement individualized person-centered care plans to address dementia and cognitive loss displayed by one of four residents reviewed (Resident 35). Findings include: Review of the facility "Dementia-Clinical Protocol" policy last reviewed 2/3/25, indicated for an individual with a confirmed dementia diagnosis, the interdisciplinary team will identify a resident-care centered care plan to maximize remaining function and quality of life. Review of Resident R35's clinical record indicated she was admitted to the facility on 3/9/22, with a diagnosis of dementia (loss of memory, language, problem-solving, and other thinking abilities that interfere with daily life), anxiety, and depression. A review of Resident 35's Minimum Data Set	F 0744		

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F 0744 SS=D	Continued from page 101 Assessment (MDS, a form completed at specific intervals to determine care needs) dated 12/22/24, indicated that the facility assessed Resident R635 as having a diagnosis of dementia. A review of Resident R35's clinical record from 3/9/22, through 2/5/25, failed to indicate that the facility had developed and implemented a person-centered care plan to address the resident's dementia and cognitive loss. Interview on 2/5/24, at 1:25 p.m. Licensed Practical Nurse, Employee E17 confirmed the facility had no further documentation that the facility developed and implemented individualized person-centered care plans to address Resident R35's dementia diagnosis. Interview on 2/5/25, at 1:32 the Vice President of Clinical Services, Employee E9 confirmed the facility failed to develop and implement individualized person-centered care plans to address dementia and cognitive loss displayed by one of four residents reviewed (Resident 35).	F 0744		

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F 0744 SS=D	Continued from page 102 28 Pa Code 211.12 (d)(1)(3)(5) Nursing services	F 0744		
F 0758 SS=D		F 0758		

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F 0758 SS=D	Continued from page 103 483.45(c)(3)(e)(1)-(5) Free from Unnec Psychotropic Meds/PRN Use §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and	F 0758	Resident # 35s Haldol orders were updated with correct indication for use by the DON/Designee. Resident # 43s order for Risperdal was updated to include the correct indication for use by the DON/Designee. All residents receiving antipsychotics have the potential to be affected. The DON/Designee will audit all current residents on antipsychotics to ensure the medication orders have the correct indication for use. The DON/Designee will educate licensed nurses on the facility policy for antipsychotic medication use. The DON/Designee will audit new antipsychotic orders 2x per week x 4 weeks to ensure orders include the correct indication for use. Results of the audits will be forwarded to the center QAPI	Completion Date: **03/17/2025** Status: **APPROVED** Date: **02/27/2025**

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F 0758 SS=D	Continued from page 104 §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by:	F 0758	committee for review and recommendations.	

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F 0758 SS=D	Continued from page 105 Based on facility policy review, clinical record review, and staff interview, it was determined that the facility failed to make certain that residents receiving psychotropic medications have adequate indication for use for two of five sampled residents (Resident R35 and R43). Findings include: Review of the facility policy "Psychotropic Medication Use" dated 2/3/25, indicated residents will not receive medications that are not clinically indicated. Review of Resident R35's clinical record indicated she was admitted to the facility on 3/9/22, with a diagnosis of dementia (loss of memory, language, problem-solving, and other thinking abilities that interfere with daily life), anxiety, and depression. A review of Resident 35's Minimum Data Set Assessment (MDS, a form completed at specific intervals to determine care needs) dated 12/22/24,	F 0758		

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F 0758 SS=D	Continued from page 106 indicated that diagnoses were current. Review of Resident R35's physician order dated 1/26/25, indicated to administer 1.5ml of 2mg/ml Haloperidol Lactate at bedtime for schizophrenia. Review of Resident R35's physician order dated 1/26/25, indicated to administer 1 ml of 2mg/ml Haloperidol Lactate one time a day for schizophrenia. Review of Resident R35's clinical record on 2/5/25, at 11:00 a.m. failed to reveal a diagnosis of schizophrenia. Interview on 2/5/25, at 1:32 the Vice President of Clinical Services, Employee E9 confirmed the facility failed to ensure Resident R35's medication regime was free from potentially unnecessary medications. Review of the admission record indicated R43 was admitted to the facility on 6/13/23.	F 0758		

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F 0758 SS=D	Continued from page 107 Review of Resident R43's MDS dated 1/15/25, indicated the diagnoses of schizophrenia (a disorder that affects a person's ability to think, feel, and behave clearly), seizure disorder (a person experiences abnormal behaviors, symptoms and sensations, sometimes including loss of consciousness), and anemia. Review of Resident R43's physician order dated 10/25/24, indicated Risperdal (an anti-psychotic medication) give 0.5 mg (milligrams) two times a day for depression. Review of Resident R43's Medication Administration Record (MAR) dated February 2025, indicated resident was receiving the medication as prescribed. Interview on 2/5/25, at 2:38 p.m. Registered Nurse (RN) Supervisor Employee E13 confirmed the facility failed to have an appropriate indication for use diagnosis in the physician order for the	F 0758		

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F 0758 SS=D	Continued from page 108 antipsychotic medication Risperdal. Interview on 2/6/25, at 3:00 p.m. the Director of Nursing confirmed the facility failed to make certain that residents receiving psychotropic medications have adequate indication for two of five sampled residents (Resident R35 and R43). 28 Pa. Code: 201.14(a) Responsibility of licensee. 28 Pa. Code: 201.18(a)(b)(3) Management. 28 Pa. Code: 211.12 (d)(1)(3)(5) Nursing services.	F 0758		
F 0761 SS=D		F 0761		

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F 0761 SS=D	Continued from page 109 483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by:	F 0761	1. No residents were negatively affected by the deficient practice. 2. An audit was conducted of all med room and med carts to ensure that medications for external use, hazardous drugs, and biologicals are clearly marked and stored separated from other medications and dated with the "opened" date. 3. Nursing staff will be educated by the DON/Designee on the policy that medications for external use, hazardous drugs, and biologicals are clearly marked and stored separated from other medications and dated with the "opened" date. Additionally, there will be no items stored below the sink in med rooms. 4. Audits of med rooms and medication carts will be performed by DON/Designee to ensure that medications are labeled and med rooms are free of clutter. These audits will be performed 3x a week times 2 weeks, 2x a week times 2 weeks, and 1x a week times 2 weeks.	Completion Date: **03/17/2025** Status: **APPROVED** Date: **02/27/2025**

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F 0761 SS=D	Continued from page 110 Based on review of facility policy, observations and staff interview it was determined that the facility failed to properly store medical supplies and biologicals in one of five medication carts (5th floor front hall medication cart) and one of three medication rooms (6th floor medication room). Findings include: A review of the facility policy "Medication Labeling and Storage" last reviewed 2/3/25, indicates medications for external use, as well as hazardous drugs and biologicals, are clearly marked as such, and are stored separately from other medications. A review of the facility policy " Administering Medications" last reviewed 2/3/25, indicated the expiration/beyond use date on the medication label must be checked prior to administering. When opening a multi dose container, the date opened shall be recorded on the container. During an observation on 2/3/25, at 12:12 p.m. the	F 0761		

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F 0761 SS=D	Continued from page 111 5th floor front hall medication cart contained the following: . A bottle of Tums antacid tablets not labeled with date opened. . A small white bottle of shaving cream. . A can of sweet vanilla rainbow room spray. During an interview completed on 2/3/25 at 12:17 p.m. Licensed Practical Nurse (LPN) Employee E6 confirmed the above observations. During an observation of the 6th floor medication storage room the following was discovered stored under the sink: . 7 packages of briefs. . One bottle of drug disposal liquid. During an interview on 2/4/25, at 10:48 a.m. Registered Nurse (RN) Employee E1 confirmed the above observation and that the facility failed to properly store medical supplies and biologicals in one of five medication carts (5th floor front hall medication cart) and one of three medication rooms	F 0761		

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F 0761 SS=D	Continued from page 112 (6th floor medication room). 28 Pa. Code:211.12(d)(1)(2)(3)(5) Nursing services. 28 Pa. Code: 211.9(a)(1)(h)(k)(l)(1) Pharmacy services. 28 Pa. Code: 211.10(c) Resident care policies.	F 0761		
F 0812 SS=F		F 0812		

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F 0812 SS=F	Continued from page 113 483.60(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	No residents were negatively affected by the deficient practice The fan assembly, fan covers, and floors were cleaned of dust, food, and grime build-up in walk-in coolers #3 and #4. The Maintenance Director was educated by the Administrator on the need to put the walk-in cooler fan assembly and cover on a preventive maintenance schedule so that they are cleaned on a quarterly basis. Dietary staff were educated on the need pull all stored materials on the floor prior to mopping the floor in all walk-in coolers. Maintenance has placed the fans on the walk-in coolers on a quarterly preventative maintenance program so they will be on a scheduled cleaning program. The floors in the walk-in are now placed on the daily cleaning checklist. The Dietary manager will audit the cleanliness of the walk-in coolers	Completion Date: **03/17/2025** Status: **APPROVED** Date: **02/26/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0812 SS=F	Continued from page 114	F 0812	twice weekly for 4 weeks and then weekly for 2 months. Audits and education will be submitted to the QAPI committee for review and approve so the issue does not recur.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395423	A. BLDG: __00_____ B. WING: _____	02/07/2025

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F 0812 SS=F	Continued from page 115 Based on a review of policy, observation and staff interview, it was determined that the facility failed to properly maintain kitchen equipment in a sanitary condition creating the potential for cross contamination in the main kitchen of the facility. Findings include: Review of facility policy "Food Safety Requirements: Sanitation of the Kitchen" dated 2/3/25, indicated that Food Service Staff maintain the sanitation of the kitchen through compliance with a written, comprehensive cleaning schedule. During an observation of the main designated kitchen on 2/3/25, initiated at 9:30 a.m., with Dietary Director Employee E25, the following was observed: - Walk-in cooler #3, at 9:45 a.m.; -- the cold air condenser fan covers had a build-up of dust, grime, and dark colored debris. -- the floor had a build-up of grime and dried food debris below stored cases of milk.	F 0812		

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F 0812 SS=F	Continued from page 116 - Walk-in cooler #4, at 9:50 a.m.; -- the cold air condenser fan covers had a build-up of dust, grime, and dark colored debris; areas around the cooler fans immediately adjacent to and on ceiling forward of the fans had a build-up of dust, grime, and dark colored debris. Above observations were confirmed by Dietary Director Employee E25 at time viewed with surveyor. During an interview on 2/3/25, at 9:52 a.m., Dietary Director Employee E25 confirmed that the facility failed to properly maintain kitchen equipment in a sanitary condition creating the potential for cross contamination in the main kitchen of the facility. 28 Pa. Code: 201.14(a) Responsibility of licensee. 28 Pa. Code: 201.18(b)(1) Management.	F 0812		

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F 0812 SS=F	Continued from page 117	F 0812		
F 0880 SS=E		F 0880		

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F 0880 SS=E	Continued from page 118 483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported;	F 0880	Unable to rectify COVID testing for residents R80 and R369. LPN/IP Employee E20 will be re-educated on Infection Preventionist Role and job description and the facility policy for testing residents for COVID-19. Facility will provide training to Employee E20 from sister facility Infection Preventionist. Education with Licensed nursing staff on proper handwashing during medication pass, and the facility policy for testing residents for COVID-19 will be conducted by DON/Designee. Audits will be performed weekly x 4 weeks by the DON/Designee to ensure compliance with testing residents for COVID-19. The DON/Designee will conduct handwashing Audits during random medication passes 3x a week times 2 week, 2x a week times x2 weeks, 1x a week times 2 weeks until compliance	Completion Date: **03/17/2025** Status: **APPROVED** Date: **02/27/2025**

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F 0880 SS=E	Continued from page 119 (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by:	F 0880	is met. Findings from the audits will be presented at QAPI quarterly meetings for review and recommendations.	

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F 0880 SS=E	Continued from page 120	F 0880		

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F 0880 SS=E	Continued from page 121 Based on review of facility policy, resident clinical records, observation, and staff interviews, it was determined that the facility failed to report, implement infection monitoring and management for COVID-19, and test residents timely for respiratory illnesses for two of two residents (Resident R80 and R369) and failed to prevent cross contamination during a medication pass for one of two residents (Resident R37). Finding include: Review of the facility "Outbreak of Communicable Diseases" reviewed 1/15/24, indicated outbreaks of communicable diseases within the facility are promptly identified and managed. An outbreak is defined as one case of an infection that is highly communicable or has serious implications. The administrator is responsible for communicating data about reportable diseases to the health department. The infection preventionist and director of nursing are responsible for managing surveillance data, monitoring ill residents and staff.	F 0880		

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F 0880 SS=E	Continued from page 122 Review of the "Bureau of Epidemiology Respiratory Virus Outbreak Toolkit" last updated 11/14/24, indicated long term care facilities need to procure their own testing supplies and the lab support needed to detect respiratory viruses like COVID-19, Influenza, and RSV in both residents and Health Care Personnel. If the respiratory virus is not one of the three for which there are point0of0care tests available, a lab needs to be available to perform an expanded respiratory panel. One laboratory-confirmed COVID-19 case indicates an outbreak. All respiratory outbreaks are reportable and must be reported to Department of Health within 24 hours of identification of the outbreak. When respiratory illness is first identified in residents or staff ,the facility should implement daily symptoms monitoring and testing. A case line listing is designed to collect information about ill cases for residents and staff during an outbreak and can track the spread of the virus and monitor case counts until the outbreak has finished. An outbreak is considered "over: when 14 days have passed	F 0880		

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F 0880 SS=E	Continued from page 123 since he last resident tested positive or became symptomatic (if no positive test). Any new infections in a resident for the applicable virus would restart the 14-daycountdown. Review of the facility policy "Administering Medications" last reviewed 2/3/25, indicates staff shall follow established facility infection control procedures (e.g., handwashing, antiseptic techniques, gloves, isolation precaution, etc.) for the administration of medications, as applicable. Review of the clinical record indicated Resident R369 was admitted to the facility on 12/10/24. Review of Resident R369's Minimum Data Set (MDS - a periodic assessment of care needs) dated 12/17/24, indicated diagnoses of opioid dependence, respiratory conditions due to smoke inhalation, and hip fracture. Review of Resident R369's progress note dated 12/19/25, indicated the resident complained of	F 0880		

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F 0880 SS=E	Continued from page 124 shortness of breath while sitting and walking. Resident R369 was not tested for respiratory illnesses. Review of Resident R369's progress note dated 12/20/24, at 9:14 a.m. indicated the resident had increased anxiety and a moist productive cough. Resident had left lower scattered rhonchi. It was indicated the resident was self-expectorating white phlegm. Resident R369 was not tested for respiratory illnesses. Review of Resident R369's progress note dated 12/23/24, indicated the resident was waiting to go to an appointment in the lobby and complained of shortness of breath and his heart racing. The resident was sent to hospital for further evaluation. Review of Resident R369's progress note dated 12/24/24, entered by Infection Preventionist, Employee E20 indicated the resident tested positive for COVID. "Will retest in 5 days per CDC recommendations".	F 0880		

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F 0880 SS=E	Continued from page 125 Review of documentation provided to the local state field office from 12/23/24, to 2/4/25, failed to include Resident R369's positive COVID diagnosis. Review of the clinical record indicated Resident R80 was admitted to the facility on 2/17/24. Review of Resident R80's MDS dated 12/12/24, indicated diagnoses of anxiety, depression, and muscle weakness. Review of Resident R80's progress note dated 1/1/25, indicated the resident has a cough and congestion. It was indicated the resident had audible wheezing noted on both inspiration and expiration. Resident R80 was not tested for respiratory illnesses during the facility's COVID outbreak. Review of Resident R80's progress note dated 1/3/25, indicated Registered Nurse, Employee E19 was called to assess the resident. It was indicated the resident was short of breathe and rhonchi	F 0880		

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F 0880 SS=E	Continued from page 126 (abnormal loud, continuous, low-pitched, snoring, or gurgling lung sound) was noted in the upper lungs. The resident's oxygen saturation (refer to the amount of oxygen circulating in the blood) was 84% on room air and 3 liters (L) of oxygen was applied via nasal cannula and the residents oxygen saturation improved to 90%. The resident's doctor and family was notified and the resident was transferred to the hospital. The resident was admitted with cough. During an interview on 2/5/25,at 10:21 a.m. Infection Preventionist, Employee E20 stated the facility in not currently in outbreak for COVID. The last outbreak was when Resident R369 tested positive for COVID was on 12/24/24. IP, Employee E20 indicated the facility completed a unit-based approach for outbreak testing. IP, Employee E20 stated she tested residents the day she received notification Resident R369 tested positive and on Day 5. IP, Employee failed to test residents on Day 3, as required. IP, Employee E20 stated the facility monitored residents after Day 5 and tested residents if they developed symptoms.	F 0880		

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F 0880 SS=E	Continued from page 127 IP, Employee E20 confirmed the facility failed to develop a line listing report for the facility's COVID outbreak that began on 12/24/24. During an interview on 2/6/25, at 9:16 a.m. the Vice President of Clinical Services, Employee E9 confirmed the facility failed to report, implement infection monitoring and management for COVID-19, and test residents timely for respiratory illnesses for two of two residents (Resident R80 and R369). During a medication pass observation completed on 2/4/25, at 9:00 a.m. Licensed Practical Nurse (LPN) Employee E23 administered Resident R152's medications, exited the room, removed gloves, donned a new pair of gloves, and began to prepare Resident R37's medications without completing hand hygiene. During an interview completed on 2/4/25, at 9:12 a.m. LPN Employee E23 confirmed administration of Resident R152's medication, exiting the room,	F 0880		

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F 0880 SS=E	Continued from page 128 removing gloves and donning a new pair of gloves without completing hand hygiene prior to beginning the preparation of R37's medications and that the facility failed to prevent cross contamination during a medication pass for one of two residents (Resident R37). 28 Pa. Code: 201.14(a) Responsibility of licensee. 28 Pa. Code 211.12(d)(1)(2)(5) Nursing services 28 Pa. Code: 211.12(d)(3) Nursing services.	F 0880		
F 0881 SS=D		F 0881		

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F 0881 SS=D	Continued from page 129 483.80(a)(3) Antibiotic Stewardship Program §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. This REQUIREMENT is not met as evidenced by:	F 0881	The facility's Infection Preventionist will be re-educated by the DON/Designee on job description and Antibiotic Stewardship Program to ensure proper compliance. The DON/Designee will audit antibiotics monthly x 3 months to ensure compliance with the facility's antibiotic stewardship program. The results of the education and audits will be shared at the monthly QAPI meeting for review and approval.	Completion Date: **03/17/2025** Status: **APPROVED** Date: **02/27/2025**

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F 0881 SS=D	Continued from page 130 Based on review of the facility's infection control policies and procedures and staff interview, it was determined that the facility failed to implement an antibiotic stewardship program for four of ten months (April 2024, May 2024, June 2024, July 2024). Findings include: Review of facility policy "Infection Control Program" reviewed 1/15/24, indicated antibiotics will be prescribed and administered to residents under the guidance of the facility's antibiotic stewardship program. The purpose of the facility's Antibiotic Stewardship Program is to monitor the use of antibiotics in the residents. Review of facility policy "Surveillance for Infections, last reviewed 1/15/24, indicated The Infection Preventionist will conduct ongoing surveillance for Healthcare-Associated Infections (HAIs) and other epidemiologically significant infections that have substantial impact on potential resident outcome and	F 0881		

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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 0881 SS=D	Continued from page 131 that may require transmission-based precautions and other preventative interventions. The Infection Preventionist or designated infection control personnel is responsible for gathering and interpreting surveillance data. Review of the facility's Infection Control surveillance for April 2024 - January 2025, failed to include documentation to indicate that antibiotic monitoring was completed for four of ten months (April through July 2024). During an interview on 2/5/24, at 2:45 p.m., the Vice President of Clinical Services confirmed that the facility failed to implement an antibiotic stewardship program that included a system of surveillance to monitor antibiotic use and lab correlation for infections for four of ten months and was unable to produce the tracking records for April 2024, May 2024, June 2024, and July 2024. 28 Pa. Code: 201.14(a) Responsibility of licensee. 28 Pa. Code: 201.18 (b) (1) (e) (1) Management.	F 0881		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395423	A. BLDG: __00_____ B. WING: _____	02/07/2025

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F 0881 SS=D	Continued from page 132 28 Pa. Code: 211.10(c)(d) Resident care policies. 28 Pa. Code: 211.12(d)(1)(5) Nursing services	F 0881		
F 0919 SS=D		F 0919		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0919 SS=D	Continued from page 133 483.90(g)(1)(2) Resident Call System §483.90(g) Resident Call System The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area from- §483.90(g)(1) Each resident's bedside; and §483.90(g)(2) Toilet and bathing facilities. This REQUIREMENT is not met as evidenced by:	F 0919	The resident call system in rooms 6010, 6011, 6012, 6013, 6016, 6017, 6018, 6019, 6020, 6021, 6023, 6040 have been repaired and now function properly. The resident call system in all resident rooms and bathrooms has been audited by the Maintenance Director to ensure each is functioning properly. The maintenance department will be educated by the Administrator on routine maintenance and testing of the call system. The Administrator will educate the nursing department to promptly notify the maintenance department with any issues related to the call system. The Administrator/Designee will randomly audit 5 resident rooms per week x 4 weeks to ensure the call system is functioning properly in the resident room and bathroom.	Completion Date: **03/17/2025** Status: **APPROVED** Date: **02/27/2025**

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 0919 SS=D	Continued from page 134	F 0919	The results of the education and audits will be shared at the monthly QAPI meeting for review and approval.	

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F 0919 SS=D	Continued from page 135 Based on observation and staff interview, it was determined that the facility failed to maintain an effective call system for 12 of 20 resident restrooms on one of five floors (6th floor). Findings include: Review of facility policy "Call System, Resident" last reviewed 2/3/25, indicates residents are provided with a means to call staff for assistance through a communication system that directly calls a staff member or a centralized work station During a group interview on 2/4/25, at 10:15 a.m. Residents indicated that the call bell in the bathroom did not work and it didn't let staff know that they needed help. During an observation on 2/5/25, 10:30 am thru 11:08 a.m. of the sixth-floor resident restrooms the following rooms were observed to have call light cords that when pulled were unable to be alarmed: . 6010	F 0919		

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F 0919 SS=D	Continued from page 136 . 6011 . 6012 . 6013 . 6016 . 6017 . 6018 . 6019 . 6020 . 6021 . 6023 . 6040 During an interview completed on 2/4/25, at 11:10 a.m. Nurse Aid (NA) Employee E26 confirmed the above observations. During an interview completed on 2/4/25, at 11:34 a.m. the Nursing Home Administrator confirmed that the facility failed to maintain an effective call system for 12 of 20 resident restrooms on one of five floors (6th floor). 28 Pa Code 201.14 (a) Responsibility of licensee.	F 0919		

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F 0919 SS=D	Continued from page 137 28 Pa Code 201.18 (b)(1) Management.	F 0919		
F 0947 SS=D		F 0947		

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F 0947 SS=D	Continued from page 138 483.95(g)(1)-(4) Required In-Service Training for Nurse Aides §483.95(g) Required in-service training for nurse aides. In-service training must- §483.95(g)(1) Be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year. §483.95(g)(2) Include dementia management training and resident abuse prevention training. §483.95(g)(3) Address areas of weakness as determined in nurse aides' performance reviews and facility assessment at § 483.71 and may address the special needs of residents as determined by the facility staff. §483.95(g)(4) For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. This REQUIREMENT is not met as evidenced by:	F 0947	Annual in-service education to include QAPI, communication, and ethics to be provided to employees E3, E14, and E15 by the Director of Nursing (DON)/designee. The DON/Designee will provide education on QAPI, communication and Ethics to all current nurse aides. The facility staff educator and human resources director will be educated by the Administrator/Designee on the required annual Inservice requirements for nursing assistants. The Administrator/Designee will randomly audit 2 nursing assistant employee files monthly x 3 months to ensure completion of the required annual education. Findings from the audits will be presented at QAPI quarterly meetings for review and recommendations.	Completion Date: **03/17/2025** Status: **APPROVED** Date: **02/27/2025**

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F 0947 SS=D	Continued from page 139 Based on review of facility documentation and interviews with staff, it was determined that the facility failed to develop, implement, and maintain an effective training program that was sufficient to meet the requirement for facility-provided annual nurse aide education for three of five employee files (Nurse Aide (NA) Employees E3, E14, and E15). Findings include: Review of NA Employee E3's personnel record indicated she was hired to the facility on 9/9/20. Review of NA Employee E14's personnel record indicated she was hired to the facility on 10/22/14. Review of NA Employee E15's personnel record indicated she was hired to the facility on 8/19/20. Review of annual in-service documentation and personnel records did not include an annual in-service training on Quality Assurance and Performance Improvement (QAPI),	F 0947		

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F 0947 SS=D	Continued from page 140 Communication, and Compliance and Ethics training. Interview on 2/5/25, at 1:54 p.m. the Director of Nursing confirmed that facility failed to develop, implement, and maintain an effective training program that was sufficient to meet the requirement for facility-provided annual nurse aide education for three of five employee files (Nurse Aide (NA) Employees E3, E14, and E15). 28 Pa. Code 201.18(b)(1) Management 28 Pa. Code 201.20 (a) (c) Staff development 28 Pa. Code 201.29 (d) Resident rights 28 Pa. Code 201.19(7) Personnel policies and procedures.	F 0947		

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P 1020	Responsibility of licensee. (a) The licensee is responsible for meeting the minimum standards for the operation of a facility as set forth by the Department and by other Federal, State and local agencies responsible for the health and welfare of residents. This includes complying with all applicable Federal and State laws, and rules, regulations and orders issued by the Department and other Federal, State or local agencies. This REGULATION is not met as evidenced by:	P 1020	Data for 6/6 months are not able to be rectified by facility for previous data. IP Employee E20 will be re-educated on Infection Control and Prevention responsibilities by the DON of at least quarterly infection control meetings per regulation with 9 required in person signatures. Team members of the infection control committee will be educated on attendance requirements by the DON/Designee. The Infection Preventionist will conduct a quarterly infection control meeting in the month of April for the first quarter. The DON/Designee will audit quarterly meetings x 2 to ensure meeting occur per regulation. The results of the education and audits will be shared at the monthly QAPI meeting for review and approval.	Completion Date: **03/17/2025** Status: **APPROVED** Date: **02/27/2025**

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

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P 1020	Continued from page 1 Based on staff interview and review of the facility's Infection Control Committee attendance records, the facility failed to provide evidence that the nine required multidisciplinary members were present at the Infection Control meetings for six of six months (8/2024 - 1/2025) and failed to produce signature sheets for six of six months (2/2024 - 7/2024). Findings include: Review of Act 52 (The Act of March 20, 2002, P.L. 154, No. 13), known as the Medical Care Availability and Reduction of Error (MCARE) Act, Chapter 4, Section 403(1) Infection Control plan states, "A health care facility... shall develop and implement an internal infection control plan that shall include... a multidisciplinary committee including representatives from each of the following if applicable to that specific health care facility." A review of the applicable members at infection control meetings includes medical staff, administration, laboratory personnel, nursing staff, pharmacy staff, physical plan personnel, patient	P 1020		

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P 1020	Continued from page 2 safety officer, a community member, and a member of the infection control team. Review of the facility's Infection Control Committee Attendance Log for 8/2024, 9/2024, 10/2024, 11/2024, 12/2024, and 1/2025, had the Administrator, Medical Director, and Community Member (outside guest) with photocopied signatures. The facility was unable to produce signature sheets for 2/2024, 3/2024, 4/2024, 5/2024, 6/2024, and 7/2024. Interview on 2/6/25, at 11:07 a.m., the Director of Nursing confirmed the facility failed to provide evidence that the nine required multidisciplinary members were present at the Infection Control meetings for six of six months (8/2024 - 1/2025) and failed to produce signature sheets for six of six months (2/2024 - 7/2024).	P 1020		

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P 5520		P 5520		

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P 5520	Continued from page 4 Nursing services. (3) Effective July 1, 2024, a minimum of 1 nurse aide per 10 residents during the day, 1 nurse aide per 11 residents during the evening, and 1 nurse aide per 15 residents overnight. This REGULATION is not met as evidenced by:	P 5520	There were no adverse effects to the residents of our facility as a result of the decreased nurse aide to resident ratios on 12/8/24, 12/10/24, 12/12/24, 1/19/25, 1/20/25, 1/24/25, and 2/1/25. The Director of Nursing, Human Resources, and the Scheduler will be re-educated on new July 1 nurse aide to resident ratios by the Nursing Home Administrator/Designee. To ensure sufficient nursing aide staffing ratios to comply with state laws, staffing meetings will be held 3 days a week to review staffing and the projected nursing assistant staff ratios for the current day, as well as the upcoming week.If projected staffing levels are below the required minimum staffing ratios, then the facility will reach out to current staff and to the staffing agencies to enlist staff to meet the minimum staffing and ratio requirement. Facility will continue to recruit CNAs through all platforms and utilize bonuses and outside staffing agencies. Audits of nurse aide ratios	Completion Date: **03/17/2025** Status: **APPROVED** Date: **02/26/2025**

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P 5520	Continued from page 5	P 5520	will be completed weekly x4 by the NHA/designee to ensure nurse aide ratios are met. Results of the audits will be reported to our QAPI committee monthly for review and recommendations.	

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P 5520	Continued from page 6 Based on review of nursing time schedules and staff interviews, it was determined that the facility administrative staff failed to provide a minimum of one nurse aide per 10 residents during the day shifts, one nurse aide per 11 residents on evening shift, and one nurse aide per 15 residents on night shift, on 7 of 21 days (12/8/14, 12/10/24, 12/12/24, 1/19/25, 1/20/25, 1/24/25, and 2/1/25). Findings include: Review of the nursing schedules and census information for 12/8/24, through 12/14/24, 1/19/25, through 1/25/25, and 1/20/25, through 2/5/25, revealed that the facility failed to meet the following: - 12/8/24: Daylight shift required 127.50 hours of Nurse Aide (NA) care, facility provided 103.19; Evening shift required 115.91 hours of NA care, facility provided 98.39; census was 170. - 12/10/24: Evening shift required 115.23 hours Nurse Aide (NA) care, facility provided 111.07; Night shift required 84.50 hours of NA care, facility provided 72.49; census was 169.	P 5520		

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P 5520	Continued from page 7 - 12/12/24: Night shift required 83.00 hours of Nurse Aide (NA) care, facility provided 76.44; census was 166. - 1/19/25: Evening shift required 113.18 hours of Nurse Aide (NA) care, facility provided 93.80; census was 166. - 1/20/25: Night shift required 83.50 hours of Nurse Aide (NA) care, facility provided 65.40; census was 167. - 1/24/25: Evening shift required 108.41 hours of Nurse Aide (NA) care, facility provided 102.30; census was 159. - 2/1/25: Daylight shift required 118.50 hours of Nurse Aide (NA) care, facility provided 105.73; census was 158. During an interview on 2/7/25, at 1:25 p.m., the Nursing Home Administrator (NHA) confirmed that the facility failed to provide a minimum of one nurse aide per 10 residents during the day shifts, one nurse aide per 11 residents on evening shift, and one nurse aide per 15 residents on night shift, on 7 of 21 days (12/8/14, 12/10/24, 12/12/24, 1/19/25, 1/20/25,	P 5520		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395423	A. BLDG: 00 B. WING:	02/07/2025

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P 5520	Continued from page 8 1/24/25, and 2/1/25).	P 5520		
P 5530		P 5530		

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P 5530	Continued from page 9 Nursing services. (4) Effective July 1, 2023, a minimum of 1 LPN per 25 residents during the day, 1 LPN per 30 residents during the evening, and 1 LPN per 40 residents overnight. This REGULATION is not met as evidenced by:	P 5530	There were no adverse effects to the residents of our facility as a result of decreased licensed nurse staffing ratios on 12/10/24, 1/19/25, and 1/25/25. The Director of Nursing, Human Resources, and the Scheduler will be re-educated on the New July 1 licensed nurse to resident ratios by the Nursing Home Administrator or Designee. Staffing meetings will be held 3 days a week to review the licensed nursing staff ratios for the previous and current day, as well as the upcoming week to ensure appropriate staffing levels.If projected staffing levels are below the state mandated ratios, then the facility will reach out to current staff and to the staffing agencies to enlist staff to meet the minimum requirement. Facility will continue to recruit licensed nurses through all platforms. Audits of licensed nursing staff will be completed weekly x4 by the NHA/Designee to	Completion Date: **03/17/2025** Status: **APPROVED** Date: **02/26/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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P 5530	Continued from page 10	P 5530	ensure licensed staff ratios meet the state minimums. Results of the audits will be reported to our QAPI committee monthly for review and recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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P 5530	Continued from page 11 Based on review of nursing time schedules and staff interviews, it was determined that the facility administrative staff failed to provide a minimum of one licensed practical nurse (LPN) per 30 residents on the evening shift, and one licensed practical nurse (LPN) per 40 residents on the overnight shift, on 3 of 21 days (12/10/24, 1/19/25, and 1/25/25). Findings include: Review of facility census data indicated that on 12/10/24, the facility census was 169, which required 5.63 licensed practical nurses (LPN's) during the evening shift. Review of the nursing time schedules revealed 4.95 LPNs provided care on the evening shift 12/10/24. No additional excess higher-level staff were available to compensate this deficiency. Review of facility census data indicated that on 1/19/25, the facility census was 166, which required	P 5530		

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P 5530	Continued from page 12 5.53 licensed practical nurses (LPN's) during the evening shift. Review of the nursing time schedules revealed 5.50 LPNs provided care on the evening shift 1/19/25. No additional excess higher-level staff were available to compensate this deficiency. Review of facility census data indicated that on 1/25/25, the facility census was 159, which required 3.98 licensed practical nurses (LPN's) during the overnight shift. Review of the nursing time schedules revealed 3.06 LPNs provided care on the evening shift 1/25/25. No additional excess higher-level staff were available to compensate this deficiency. During an interview on 2/7/25, at 1:25 p.m., the Nursing Home Administrator (NHA) confirmed that the facility failed to provide a minimum of one licensed practical nurse (LPN) per 30 residents on the evening shift, and one licensed practical nurse	P 5530		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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P 5530	Continued from page 13 (LPN) per 40 residents on the overnight shift, on 3 of 21 days (12/10/24, 1/19/25, and 1/25/25).	P 5530		

Certified End Page

CORNER VIEW NURSING AND REHABILITATION CENTER

STATE LICENSE NUMBER: 060402

SURVEY EXIT DATE: 02/07/2025

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

Jeanne Parisi
Deputy Secretary for Quality Assurance

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

Pennsylvania
Department of Health

THIS IS A CERTIFICATION PAGE

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