STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395471	A. BLDG: 00 B. WING:	12/20/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
ARMSTRONG REHABILITATION AND NURSING CENTER STATE LICENSE NUMBER: **530602**	**265 S MCKEAN STREET KITTANNING, PA 16201**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0000	INITIAL COMMENT Based on a Medicare/Medicaid Recertification survey, State Licensure survey, Civil Rights Compliance, and an Abbreviated survey in response to four complaints completed on December 20, 2024, it was determined that Armstrong Rehabilitation and Nursing Center was not in compliance with the following requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care and the 28 Pa. Code, Commonwealth of Pennsylvania Long Term Care Licensure Regulations	F 0000		
F 0552 SS=D		F 0552		

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 0552 SS=D	Continued from page 1 483.10(c)(1)(4)(5) Right to be Informed/Make Treatment Decisions §483.10(c) Planning and Implementing Care. The resident has the right to be informed of, and participate in, his or her treatment, including: §483.10(c)(1) The right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition. §483.10(c)(4) The right to be informed, in advance, of the care to be furnished and the type of care giver or professional that will furnish care. §483.10(c)(5) The right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she prefers. This REQUIREMENT is not met as evidenced by:	F 0552	Resident R39 and R66 concerns were addressed by the appointments being rescheduled. A new process was implemented to ensure that residents are aware of their appointments timely. This process involves activities delivering appointment sheets when they pass out mail so the resident has prior knowledge of appointment details. Education on the new process of informing residents when their appointments are, will be provided to nursing, activities, and resident council by Administrator or designee on or before 2/18/2025. Audits will be conducted by the DON or designee to ensure the appointment process is being followed 3 x a week x 4 weeks and monthly X 1 month. Audit results will be reviewed through the monthly QAPI process/meeting.	Completion Date: **02/11/2025** Status: **APPROVED** Date: **01/28/2025**

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F 0552 SS=D	Continued from page 2 Based on review of facility policy, clinical records, group interview, and staff interviews, it was determined that the facility failed to inform residents in advance of the proposed care for two of seven residents (Resident R39 and Resident R66). Findings include: The facility policy "Resident rights" reviewed 12/3/24, indicated that the facility will support and facilitate a resident's right to request, refuse, and discontinue medical or surgical treatment. The facility will provide the resident information in a manner that is easy to understand. During a group interview on 12/17/24, at 1:30 p.m. two of seven residents voiced concerns of not knowing in advance of when their appointments are. During a group interview residents stated they used to get index cards prior to their appointment with who their appointment was for, date, and what time their appointment was for.	F 0552		

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F 0552 SS=D	Continued from page 3 During a group interview residents voiced concern about not having enough time to prepare for an appointment and stated "I'd like to know at least a day ahead so I know that I need to get ready instead of the same day", and "I only know that I have an appointment because the staff will come in and say it's time to get ready for your appointment today". During an interview on 12/18/24, at 2:32 p.m. Ward Clerk Employee E5 stated, "I haven't figured out a process yet to notify the residents. I used to give them index cards but that didn't work". During an interview on 12/18/24, at 3:00 p.m. the Nursing Home Administrator confirmed that the facility failed to inform residents in advance of the proposed care for two out of seven residents (Resident R39, and Resident R66). 28 Pa. Code 201.29(j) Resident rights. 28 Pa. Code 211.12(d)(1) Nursing services.	F 0552		

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F 0558 SS=D	483.10(e)(3) Reasonable Accommodations Needs/Preferences §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by:	F 0558	Social Worker immediately completed the application for a free phone for R71. Whole house audit completed to ensure no other resident needs need to be completed. Education on resident rights and reasonable accommodations will be provided to the social worker by the NHA or designee on or before 2/18/2025. Audits will be conducted by DON or designee to ensure no other outstanding needs need to be completed weekly x 4 weeks and monthly x 1 month. Audit results will be reviewed through the monthly QAPI process/meeting.	Completion Date: **02/11/2025** Status: **APPROVED** Date: **01/28/2025**

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F 0558 SS=D	Continued from page 5 Based on clinical record review, staff and resident interview, it was determined that the facility failed to accommodate resident needs and preferences for one of six residents (Resident 71). Findings include: Review of Resident R71's clinical record indicated he was admitted to the facility on 3/3/23, with diagnoses of depression, insomnia (difficulty falling or staying asleep), and orthostatic hypotension (a drop in blood pressure when you stand up, which can cause dizziness, fainting, and other symptoms). Review of Resident R71's MDS dated 9/21/24, indicated the diagnoses were current. Review of Resident R71's progress note dated 9/26/24, entered by Social Service Director, Employee E4 stated she attempted to order a free phone for the resident however was unable to complete the process as it required a debit card for a processing fee.	F 0558		

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F 0558 SS=D	Continued from page 6 During an interview on 12/16/24, at 10:43 a.m. Resident R71 stated he asked the social worker to help him apply for a free phone. He stated it's been a while. Review of Resident R71's clinical record failed to indicate any follow-up on obtaining Resident R71 a free phone as he requested. During an interview on 12/17/24, at 9:47 a.m. Social Service Director, Employee E4 stated "I have the application for phone, I still have to do one page."When asked about the debit processing fee, it was indicated the facility attempted to get him a free phone and a debit card was needed for a $2.50 processing fee. Social Service Director, Employee E4 confirmed the facility failed to accommodate resident needs and preferences for one of six residents reviewed (Resident R71). 28 Pa. Code 211.12(d)(1)(5) Nursing services	F 0558		

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F 0565 SS=E	483.10(f)(5)(i)-(iv)(6)(7) Resident/Family Group and Response §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the	F 0565	Whole house audit of resident grievances to identify any outstanding issues conducted on 1/8/2025. All previous grievances have been resolved. Residents will sign completed grievance form and will be offered a copy if requested. Education on resident /family group to ensure social worker is aware of new process of resident signing off on grievance paper will be provided to the social worker by the NHA or designee on or before 2/18/2025. Audits will be conducted on grievance process by DON or designee weekly x 4 weeks and monthly x 1 month. Audit results will be reviewed through the monthly QAPI process/meeting.	Completion Date: **02/11/2025** Status: **APPROVED** Date: **01/28/2025**

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F 0565 SS=E	Continued from page 8 facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is not met as evidenced by:	F 0565		

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F 0565 SS=E	Continued from page 9 Based on review of facility policy, facility grievance forms, group interview, resident interview, and staff interview it was determined that the facility failed to respond to concerns from facility grievances and failed to respond to concerns in a timely manner for six out of six months (June 2024 through November 2024). Findings include: The facility policy "Resident and Family Grievances" dated 12/3/24, indicated that the facility will support each residents and family members right to voice grievances without discrimination, reprisal, or fear of discrimination. The grievance official is responsible for overseeing the grievance process. The written decision will include at a minimum: - The date the grievance was received. - The steps taken to investigate the grievance. - A summary of the pertinent findings or conclusions regarding the resident ' s concern. - A statement as to whether the grievance was	F 0565		

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F 0565 SS=E	Continued from page 10 confirmed or not confirmed. - Any corrective action taken. - The date the written decision was issued. Review of facility provided grievance forms on 12/17/24, at 10:53 a.m. revealed that grievance forms were incomplete and residents or resident representatives were not made aware of the outcome of the filed grievance from June 2024 through November 2024. During a group interview on 12/17/24, at 1:30 p.m. two of seven residents voiced a concern that the facility does not notify residents of the outcome of their grievance. During an interview on 12/18/24, at 2:09 p.m. the Social Service Director Employee E4 confirmed that the facility failed to respond to concerns from facility grievances and failed to respond to concerns in a timely manner for six out of six months (June 2024 through November 2024). 28 Pa. Code 201.18(b)(1) Management	F 0565		

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F 0575 SS=E	483.10(g)(5)(i)(ii) Required Postings §483.10(g)(5) The facility must post, in a form and manner accessible and understandable to residents, resident representatives: (i) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State agencies and advocacy groups, such as the State Survey Agency, the State licensure office, adult protective services where state law provides for jurisdiction in long-term care facilities, the Office of the State Long-Term Care Ombudsman program, the protection and advocacy network, home and community based service programs, and the Medicaid Fraud Control Unit; and (ii) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulation, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, and non-compliance with the advanced directives requirements (42 CFR part 489 subpart I) and requests for information regarding returning to the community. This REQUIREMENT is not met as evidenced by:	F 0575	Postings were moved from the front entrance bulletin board to the main hallway. Additional postings were added to the second and third floor to include information on State Agency, Adult Protective Services, Medicare Fraud Unit, and how to file a complaint with state agency. Education on postings will be provided to the social worker by the NHA or designee on or before 2/18/2025. Audits will be conducted on postings to ensure required postings are present by DON or designee weekly x 4 weeks and monthly x 1 month. Audit results will be reviewed through the monthly QAPI process/meeting. F578	Completion Date: **02/11/2025** Status: **APPROVED** Date: **01/28/2025**

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F 0575 SS=E	Continued from page 12 Based on observations and staff interview it was determined that the facility failed to have required postings for the facility in areas that are accessible to all residents throughout the facility for State Agency information, Adult Protective Service information, Medicare Fraud Unit information, and how to file a complaint with State Agency on two of two nursing floors (Second and Third Floor). Findings include: Observation by the facilities entrance bulletin board had required postings displayed, however residents would be required to descend a staircase consisting of nine steps to view the postings and climb back up nine step to get back to the Main Floor. Observation on the nursing care units on the second and third floor failed to include information on State Agency, Adult Protective Services, Medicare Fraud Unit, and how to file a complaint with State Agency. During an interview on 12/19/24, at 1:39 p.m.	F 0575		

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F 0575 SS=E	Continued from page 13 Nursing Home Administrator confirmed that the facility failed to post above required information where it is easily accessible to residents to refer to, if needed, for two of two nursing floors (Second and Third Floor). 28 Pa. Code: 201.14(a)Responsibility of licensee. 28 Pa. Code: 201.18e Management.	F 0575		
F 0578 SS=D		F 0578		

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F 0578 SS=D	Continued from page 14 483.10(c)(6)(8)(g)(12)(i)-(v) Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance	F 0578	Whole house audit completed on advance directives to ensure advance directives are formulated. Advance directives, offering, documentation has been completed for residents. Resident R47 and R142 were interviewed to discuss advance directives wishes. Education on advance directives will be provided to the social worker and nursing management by the NHA or designee on or before 2/18/2025. Audits will be conducted on advance directive process by NHA or designee weekly x 4 weeks and monthly x 1 month. Audit results will be reviewed through the monthly QAPI process/meeting.	Completion Date: **02/11/2025** Status: **APPROVED** Date: **01/28/2025**

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F 0578 SS=D	Continued from page 15 directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by:	F 0578		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395471	A. BLDG: 00 B. WING:	12/20/2024

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F 0578 SS=D	Continued from page 16 Based on review of facility policy, clinical records, and staff interview, it was determined that the facility failed to provide the opportunity to formulate an advance directive (a written instruction such as a living will or durable power of attorney for health care for when the individual is incapacitated) for two of two residents (Resident R47, and R142). Findings include: A review of the facility "Resident Rights Regarding Treatment and Advance Directives" dated 12/3/24, and previously dated 9/12/24, indicated that upon admission, the facility will determine if the resident has executed an advance directive, and if not, determine whether the resident would like to formulate an advance directive. Review of Resident R47's admission record indicated the resident was admitted to the facility 3/10/23. A review of Resident R47's Minimum Data Set	F 0578		

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F 0578 SS=D	Continued from page 17 (MDS - periodic assessment of care needs) dated 11/8/24, included diagnoses of depression, diabetes (a metabolic disorder in which the body has high sugar levels for prolonged periods of time), and hyperlipidemia (a high level of fat particles in the blood). A review of the clinical record failed to reveal an advanced directive or documentation that Resident R47 was given the opportunity to formulate an Advanced Directive. A review of the medical record indicated Resident R142 was re- admitted to the facility on 12/27/24, with diagnoses that included high blood pressure, wound infection, and pain. A review of the clinical record failed to reveal an advanced directive or documentation that Resident R142 was given the opportunity to formulate an Advanced Directive. During an interview on 12/17/24, at 12:53 p.m.	F 0578		

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F 0578 SS=D	Continued from page 18 Social Worker Employee E4 confirmed that the clinical record did not include documentation that Resident R47, and R142 were afforded the opportunity to formulate Advanced Directives. 28 Pa. Code: 201.29(b)(d)(j) Resident rights.	F 0578		
F 0579 SS=E	483.10(g)(13) Posting/Notice of Medicare/Medicaid on Admit §483.10(g)(13) The facility must display in the facility written information, and provide to residents and applicants for admission, oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. This REQUIREMENT is not met as evidenced by:	F 0579	Postings were placed on the second and third floor on information on how to apply for Medicare and Medicaid. Education on postings will be provided to the social worker and BOM by the NHA or designee on or before 2/11/2025. Audits will be conducted on postings to ensure they are present by DON or designee weekly x 4 weeks and monthly x 1 month. Audit results will be reviewed through the monthly QAPI process/meeting.	Completion Date: **02/11/2025** Status: **APPROVED** Date: **01/28/2025**

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F 0579 SS=E	Continued from page 19 Based on observations and staff interview, it was determined the facility failed to display written information on applying for Medicare and Medicaid benefits and receiving refunds for previous payments covered by Medicare and Medicaid on two of two nursing units (Second, and Third Floor). Findings include: Observation by the facilities entrance bulletin board had required postings posted, however residents would be required to descend a staircase consisting of nine steps to view the postings and climb back up nine step to get back to the Main Floor. Observation on the nursing care units on the second and third floor failed to include information on how to apply for Medicare and Medicaid. During an interview on 12/19/24, at 1:39 p.m. Nursing Home Administrator confirmed that the facility failed to post above required information where it is easily accessible to residents to refer to, if	F 0579		

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F 0579 SS=E	Continued from page 20 needed, on two of two nursing units (Second and Third Floor). 28 Pa. Code: §201.29(i) Resident rights.	F 0579		
F 0580 SS=D		F 0580		

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F 0580 SS=D	Continued from page 21 483.10(g)(14)(i)-(iv)(15) Notify of Changes (Injury/Decline/Room, etc.) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this	F 0580	MD was retroactively notified regarding change of condition for R39 and R17. R17 family was informed/notified. Whole house audit completed to ensure no additional residents were affected. Nursing staff will be educated on MD and family notification for change in condition and proper documentation on or before 2/11/2025. Resident events/change in condition will be audited daily times 4 weeks and monthly times one month to ensure proper MD and family notification of events and changes in conditions. Audit results will be reviewed through the monthly QAPI process/meeting.	Completion Date: **02/11/2025** Status: **APPROVED** Date: **01/28/2025**

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F 0580 SS=D	Continued from page 22 section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by:	F 0580		

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F 0580 SS=D	Continued from page 23 Based on review of facility policy, clinical records and staff interview, it was determined that the facility failed to notify the family and/or physician of a change in condition in a timely manner for two of six residents (Resident R17 and R39). Findings include: Review of the facility policy "Notification of Changes" dated 12/3/24, indicated purpose of this policy is to ensure the facility promptly inform the resident, consults the resident's physician, and notifies, consistent with his or her authority, the resident's representative when there is a change requiring notification. The facility must inform the resident, consult with the resident's physician and/or notify the resident's family member or legal representative when there is a change requiring such notification such as a significant change in the resident's physical, mental, or psychosocial condition such as deterioration in health. This may include life threatening conditions, clinical complications, or a transfer of the resident from the	F 0580		

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F 0580 SS=D	Continued from page 24 facility. Review of the clinical record indicated that Resident R17 was admitted to the facility on 7/25/24, with diagnoses of Chronic Obstructive Pulmonary Disease (an ongoing lung condition caused by damage to the lungs), Obstructive Sleep Apnea (a sleep disorder in which the throat muscles relax and block the airway, causing breathing to become restricted and briefly stop), and respiratory failure. Review of the Minimum Data Set (MDS - a periodic assessment of care needs) dated 8/1/24, indicated the diagnoses were current. Review of Resident R17's progress note dated 10/30/24, at 10:29 p.m. indicated resident was using his stomach muscles to breath and had a red face. Resident blood pressure was 150/100, pulse 141 beats per minutes, respiration 40, temperature 100.8, and Spo2 83% on BIPAP. Resident was transferred to hospital.	F 0580		

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F 0580 SS=D	Continued from page 25 Review of Resident R17's progress note dated 10/31/24, at 8:07 a.m. indicated a call was placed to hospital for an update. It was indicated the resident was being transferred to Intensive Care Unit with respiratory failure and elevated ammonia levels. Review of Resident R17's progress note dated 11/1/24, at 11:22 a.m. indicated a call was placed to the resident's sister to make sure she knew resident was in the hospital. "Sister upset that no call from facility was made to alert her. Please call sister with any updates." During an interview on 12/19/24 11:30 a.m. the Nursing Home Administrator confirmed that the facility failed to notify the family of a change in condition in a timely manner for one of four residents (Resident R17). Review of the clinical record indicated that Resident R39 was admitted to the facility on 6/19/23, with diagnoses of overactive bladder and kidney disease.	F 0580		

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F 0580 SS=D	Continued from page 26 Review of the MDS dated 10/28/24, indicated the diagnoses were current. Review of Resident R39's progress note dated 12/1/24, indicated the resident was lethargic and weak. Did not eat breakfast. Saturated urine brief with red colored urine and urine in commode red as well. Resident was shaking and required an extensive two person assist for transfers. RN alerted and came to assess. Ordered sick tray for lunch, however resident has no appetite. Review of Resident R39's progress note dated 12/1/24, at 12:15 p.m. indicated the provider was notified about residents' status. The nurse practitioner stated to monitor and assess the resident's vitals more frequently. It was indicated if changes occur to contact the provider. Review of Resident R39's progress note dated 12/1/24, at 5:07 p.m. indicated resident was drowsy, fatigued and drifts to sleep while talking.	F 0580		

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F 0580 SS=D	Continued from page 27 Says she hurts all over, including her ears, throat, upper and lower extremities. She is shaky and dropped her water cup on the floor. Resident had loss of appetite. Bright red blood noted in urine after voiding. It was indicated the resident's daughter was notified in residents change in condition and requested for her to be sent to hospital for evaluation since she is concerned due to her rapid decline. Review of the resident's clinical record failed to reveal the resident's provider was notified as ordered. During an interview on 12/20/24, at 9:24 a.m. Assistant Director of Nursing, Employee E14 confirmed the facility failed to notify a physician for a change in condition as ordered for one of six residents (Resident R39). 28 Pa. Code: 201.29(a)(b)(c)(d)(j)(m) Resident rights. 28 Pa. Code: 201.14(a)(c)(d)(e) Responsibility of licensee. 28 Pa. Code: 211.12(d)(1)(2)(3)(5) Nursing	F 0580		

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F 0580 SS=D	Continued from page 28 services. 28. Pa. Code: 211.10(a)(c)(d) Resident care policies.	F 0580		
F 0582 SS=D	483.10(g)(17)(18)(i)-(v) Medicaid/Medicare Coverage/Liability Notice §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid	F 0582	NOMNC form notice could not be modified for R76 as resident has discharged from the building. Audit completed on like residents to ensure timeliness of provision of NOMNC were provided timely. Education on the timeliness of NOMNC will be provided to the social worker by the NHA or designee on or before 2/11/2025. All Audits will be conducted on NOMNC process by DON or designee weekly x 4 weeks and monthly x 1 month. Audit results will be reviewed through the monthly QAPI process/meeting.	Completion Date: **02/11/2025** Status: **APPROVED** Date: **01/28/2025**

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F 0582 SS=D	Continued from page 29 State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by:	F 0582		

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F 0582 SS=D	Continued from page 30 Based on a review of facility documents and staff interview, it was determined that the facility failed to ensure a Notice of Medicare Non-Coverage (NOMNC) form notice were provided timely for one of three residents (Resident R76). Findings include: Review of facility policy "Advance Beneficiary Notices" dated 12/3/24, indicated it is the policy of the facility to provide timely notices regarding Medicare eligibility and coverage. To ensure that the resident or representative had enough time to make a decision whether or not to receive the services and assume financial responsibility the notice shall be provided at least two days before the end of coverage. Review of Resident R76's admission record indicated the resident was admitted to the facility 10/23/24. Review of Resident R76's Minimum Data Set	F 0582		

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F 0582 SS=D	Continued from page 31 (MDS - periodic assessment of care needs) dated 10/30/24, included diagnoses of thyroid disorder (any dysfunction of the butterfly-shaped gland at the base of the neck), depression, and shortness of breath. Review of the NOMNC form indicated services will end 10/31/24. Resident R76 signed the NOMNC on 10/31/24. The facility failed to issue the NOMNC in a timely manner. During an interview on 12/17/24, at 12:53 p.m. the Social Service Director Employee E4 confirmed the facility failed to ensure a Notice of Medicare Non-Coverage (NOMNC) form notice were provided timely for one of three residents (Resident R76). 28 Pa. Code 201.24 (b) Admission Policy. 28 Pa. Code 201.14(a) Responsibility of Licensee.	F 0582		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395471	A. BLDG: 00 B. WING:	12/20/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
ARMSTRONG REHABILITATION AND NURSING CENTER STATE LICENSE NUMBER: **530602**	**265 S MCKEAN STREET KITTANNING, PA 16201**

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F 0582 SS=D	Continued from page 32 28 Pa. Code 201.18(b)(2) Management. 28 Pa. Code 201.29(a) Resident Rights.	F 0582		
F 0583 SS=D	483.10(h)(1)-(3)(i)(ii) Personal Privacy/Confidentiality of Records §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of	F 0583	Audits of medication carts completed to ensure no additional carts were left unattended or computer screens were open Education will be provided to the nurses on confidentiality of personal and medical records and computer screens not being opened by DON or designee on or before 2/18/2025. Audits will be conducted on locked carts weekly and computer screens being closed x 4 weeks and monthly x 1 month on various shifts. Audit results will be reviewed through the monthly QAPI process/meeting.	Completion Date: **02/11/2025** Status: **APPROVED** Date: **01/28/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0583 SS=D	Continued from page 33 personal and medical records except as provided at §483.70(h)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by:	F 0583		

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 0583 SS=D	Continued from page 34 Based on review of facility policy, observation, and staff interview it was determined that the facility failed to maintain the confidentiality of residents' medical information on one of three medication carts (2A Medication Cart). Findings include: Review of facility policy "Confidentiality of Personal and Medical Records" dated 12/3/24, indicated this facility honors the resident's right to secure and confident personal and medical records. This includes the right to confidentiality of all information contained in a resident's records, regardless of the form of storage or location of the record. During an observation on 12/16/24, at 10:42 a.m. the 2A Medication Cart outside of resident room 205 was left unattended with the computer screen open with identifiable information any passerby could see resident personal and confidential information.	F 0583		

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F 0583 SS=D	Continued from page 35 During an interview on 12/16/24, at 10:43 a.m. Registered Nurse Employee E1 confirmed the above observation and that the facility failed to maintain the confidentiality of residents' medical information as required. 28 Pa. code: 211.5(b) Clinical records. 28 Pa. Code: 201.29(i) Resident Rights. 28 Pa. Code: 211.12(d)(3) Nursing Services.	F 0583		
F 0607 SS=D	483.12(b)(1)-(5)(ii)(iii) Develop/Implement Abuse/Neglect Policies §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, §483.12(b)(4) Establish coordination with the QAPI	F 0607	Resident R6 incident was reported on 1/27/25. House audit completed to ensure submission of any other incidents that involve abuse/neglect. Education on reporting process will be provided to the social worker and interim DON by the NHA or designee on or before 2/11/2025. Audits will be conducted on correct and timely submission of incidents on reporting process by DON or designee weekly x 4 weeks and monthly x 1 month. Audit results will be reviewed through the monthly QAPI process/meeting.	Completion Date: **02/11/2025** Status: **APPROVED** Date: **01/28/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0607 SS=D	Continued from page 36 program required under §483.75. §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements. §483.12(b)(5)(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act. §483.12(b)(5)(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act. This REQUIREMENT is not met as evidenced by:	F 0607		

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F 0607 SS=D	Continued from page 37 Based on review of facility documents, facility policy, clinical records, and staff interviews, it was determined that the facility failed to implement written policies and procedures to ensure a complete and thorough investigation of an allegation of neglect for one of three residents (Resident R6) and failed to conduct a criminal background check prior to the start of employment for one of five staff (Dietary Employee E21). Findings include: Review of facility policy "Abuse, Neglect, and Exploitation" dated 12/3/24, indicated neglect means failure of the facility, its employees, or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. Possible indicators of abuse include failure to provide care needs such as comfort, safety, feeding, bathing, dressing, turning and repositioning. An immediate investigation is warranted when suspicion or abuse, neglect, or exploitation, or reports of abuse, neglect,	F 0607		

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F 0607 SS=D	Continued from page 38 or exploitation occur. Potential employees will be screened for a history of abuse, neglect, exploitation, or misappropriation of resident property. A background, reference, and credentials' check shall be conducted on potential employees. The facility will maintain documentation of proof the screening occurred. Review of the clinical record indicated Resident R6 was admitted to the facility on 1/11/18. Review of Resident R6's Minimum Data Set (MDS - a periodic assessment of care needs) dated 11/28/24, indicated diagnoses of high blood pressure, anemia (too little iron in the blood), and hyperlipidemia (high levels of fat in the blood). Review of a facility "Grievance/Concern Form" dated 11/12/24, indicated the following: "Physical Therapy performing quarterly eval at 2:00 p.m. and Resident R6 revealed that she was concerned today about her care. She had put her call light on between 11:00 a.m. and 11:30 a.m. and her aide	F 0607		

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F 0607 SS=D	Continued from page 39 came in prior to lunch and shut bell off, stating there were a lot of call bells on. Resident R6 communicated she needed changed. The aide did not return until 1:40 p.m. to change her." Review of the "Results of Action Taken" section indicated the following: "Staff interviewed and educated about shutting off call lights. Social Worker spoke to resident, explained staff was educated on care and call lights. Resident was pleased." During an interview on 12/18/24 at 2:13 p.m. Social Services Director Employee E4 stated, "I went up and talked to Resident R6 and she got really upset and started crying, she said she didn't want to get anyone in trouble. She seemed ok after that. I didn't report that as neglect." During an interview on 12/19/24, at 2:13 p.m. Social Services Director Employee E4 confirmed that the facility failed to implement written policies and procedures to ensure a complete and thorough	F 0607		

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 0607 SS=D	Continued from page 40 investigation of an allegation of neglect for one of three residents (Resident R6). Review of Dietary Aide, Employee E21's employee file on 12/19/24, at 2:24 p.m. revealed a start date of 10/22/24. Review of Dietary Aide, Employee E21's employee file failed to indicate a criminal background check was completed. During an interview on 12/20/24, at 9:38 a.m. Director of Human Resources, Employee E22 confirmed the facility failed to conduct a criminal background check prior to the start of employment for one of five staff (Dietary Employee E21). 28 Pa. Code 201.14(a) Responsibility of licensee. 28 Pa. Code 201.18(e)(1) Management.	F 0607		
F 0609 SS=D		F 0609		

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F 0609 SS=D	Continued from page 41 483.12(b)(5)(i)(A)(B)(c)(1)(4) Reporting of Alleged Violations §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by:	F 0609	Resident R6 incident submitted 1/27/25. Education on reporting process will be provided to the social worker and interim DON by the NHA or designee on or before 2/11/2025. Reports need to be completed within 24 hours or for abuse cases within 2 hours. Audits will be conducted to ensure all incidents that are required to be reported are reported timely by DON or designee weekly x 4 weeks and monthly x 1 month. Audit results will be reviewed through the monthly QAPI process/meeting.	Completion Date: **02/11/2025** Status: **APPROVED** Date: **01/28/2025**

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F 0609 SS=D	Continued from page 42 Based on review of facility policy, clinical record review, reports submitted to the State, and staff interview, it was determined that the facility failed to report an allegation of neglect in the required timeframe one of three residents (Resident R6). Findings include: Review of facility policy "Abuse, Neglect, and Exploitation" dated 12/3/24, indicated neglect means failure of the facility, its employees, or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. Possible indicators of abuse include failure to provide care needs such as comfort, safety, feeding, bathing, dressing, turning and repositioning. Reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies within specified timeframes: not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury.	F 0609		

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F 0609 SS=D	Continued from page 43 Review of the clinical record indicated Resident R6 was admitted to the facility on 1/11/18. Review of Resident R6's Minimum Data Set (MDS - a periodic assessment of care needs) dated 11/28/24, indicated diagnoses of high blood pressure, anemia (too little iron in the blood), and hyperlipidemia (high levels of fat in the blood). Review of a facility "Grievance/Concern Form" dated 11/12/24, indicated the following: "Physical Therapy performing quarterly eval at 2:00 p.m. and Resident R6 revealed that she was concerned today about her care. She had put her call light on between 11:00 a.m. and 11:30 a.m. and her aide came in prior to lunch and shut bell off, stating there were a lot of call bells on. Resident R6 communicated she needed changed. The aide did not return until 1:40 p.m. to change her." Review of the "Results of Action Taken" section indicated the following: "Staff interviewed and	F 0609		

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F 0609 SS=D	Continued from page 44 educated about shutting off call lights. Social Worker spoke to resident, explained staff was educated on care and call lights. Resident was pleased." During an interview on 12/18/24 at 2:13 p.m. Social Services Director Employee E4 stated, "I went up and talked to Resident R6 and she got really upset and started crying, she said she didn't want to get anyone in trouble. She seemed ok after that. I didn't report that as neglect." Review of incidents submitted to the State Agency of 12/19/24, at 10:00 a.m. did not include the neglect allegation involving Resident R6. During an interview on 12/19/24, at 10:39 a.m. the Nursing Home Administrator (NHA) confirmed that Resident R6's allegation of neglect was not reported to the State Agency. During an interview on 12/19/24, at 10:39 a.m. the NHA confirmed that the facility failed to report an	F 0609		

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F 0609 SS=D	Continued from page 45 allegation of neglect in the required timeframe one of three residents as required. 28 Pa. Code 201.14(a)(c.)(e.) Responsibility of licensee. 28 Pa. Code 201.18(b)(1)(3)(e)(1) Management. 28 Pa. Code 201.20(b) Staff development. 28 Pa. Code 211.10(c.)(d) Resident care policies.	F 0609		
F 0610 SS=D	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.	F 0610	Resident R6 incident reported om 1/27/2025. Education on completing a thorough investigation will be provided to the social worker by the NHA or designee on or before 2/11/2025. Audits will be conducted on all incidents by completing a thorough investigation by DON or designee weekly x 4 weeks and monthly x 1 month. Audit results will be reviewed through the monthly QAPI process/meeting.	Completion Date: **02/11/2025** Status: **APPROVED** Date: **01/28/2025**

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F 0610 SS=D	Continued from page 46 This REQUIREMENT is not met as evidenced by:	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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NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
ARMSTRONG REHABILITATION AND NURSING CENTER STATE LICENSE NUMBER: **530602**	**265 S MCKEAN STREET KITTANNING, PA 16201**

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F 0610 SS=D	Continued from page 47 Based on review of facility documents, facility policy, clinical records, and staff interview, it was determined that the facility failed to conduct a thorough investigation of an allegation of neglect for one of three residents (Resident R6). Findings include: Review of facility policy "Abuse, Neglect, and Exploitation" dated 12/3/24, indicated neglect means failure of the facility, its employees, or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. Possible indicators of abuse include failure to provide care needs such as comfort, safety, feeding, bathing, dressing, turning and repositioning. An immediate investigation is warranted when suspicion or abuse, neglect, or exploitation, or reports of abuse, neglect, or exploitation occur. Review of the clinical record indicated Resident R6 was admitted to the facility on 1/11/18.	F 0610		

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F 0610 SS=D	Continued from page 48 Review of Resident R6's Minimum Data Set (MDS - a periodic assessment of care needs) dated 11/28/24, indicated diagnoses of high blood pressure, anemia (too little iron in the blood), and hyperlipidemia (high levels of fat in the blood). Review of a facility "Grievance/Concern Form" dated 11/12/24, indicated the following: "Physical Therapy performing quarterly eval at 2:00 p.m. and Resident R6 revealed that she was concerned today about her care. She had put her call light on between 11:00 a.m. and 11:30 a.m. and her aide came in prior to lunch and shut bell off, stating there were a lot of call bells on. Resident R6 communicated she needed changed. The aide did not return until 1:40 p.m. to change her." Review of the "Results of Action Taken" section indicated the following: "Staff interviewed and educated about shutting off call lights. Social Worker spoke to resident, explained staff was educated on care and call lights. Resident was	F 0610		

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F 0610 SS=D	Continued from page 49 pleased." During an interview on 12/18/24 at 2:13 p.m. Social Services Director Employee E4 stated, "I went up and talked to Resident R6 and she got really upset and started crying, she said she didn't want to get anyone in trouble. She seemed ok after that. I didn't report that as neglect." During an interview on 12/19/24, at 10:39 a.m. the Nursing Home Administrator (NHA) confirmed that they did not perform an investigation of Resident R6's allegation of neglect. During an interview on 12/19/24, at 10:39 a.m. the NHA confirmed that the facility failed to conduct a thorough investigation of an allegation of neglect for one of three residents as required. 28 Pa Code: 201.18 (e)(1)(2) Management. 28 Pa Code: 201.29 (a)(c)(d) Resident Rights. 28 Pa Code: 211.12 (a)(c)(d)(1)(3)(5) Nursing services.	F 0610		

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F 0621 SS=D	483.15(b)(1)-(3)(c)(9) Equal Practices Regardless of Payment Source §483.15(b) Equal access to quality care. §483.15(b)(1) A facility must establish, maintain and implement identical policies and practices regarding transfer and discharge, as defined in §483.5 and the provision of services for all individuals regardless of source of payment, consistent with §483.10(a)(2); §483.15(b)(2) The facility may charge any amount for services furnished to non-Medicaid residents unless otherwise limited by state law and consistent with the notice requirement in §483.10(g)(18)(i) and (g)(4)(i) describing the charges; and §483.15(b)(3) The State is not required to offer additional services on behalf of a resident other than services provided in the State plan. §483.15(c)(9) Room changes in a composite distinct part. Room changes in a facility that is a composite distinct part (as defined in § 483.5) are subject to the requirements of § 483.10(e)(7) and must be limited to moves within the particular building in which the resident resides, unless the resident voluntarily agrees to move to another of the composite distinct part's locations. This REQUIREMENT is not met as evidenced by:	F 0621	Dental appointment was made immediately for R45. R87 was immediately evaluated by therapy. Therapy was started for R87. Education will be conducted on equal access to quality care to Medical Records, Social Services, and Therapy Manager by DON or designee on or before 2/11/2025. Audits will be conducted by DON or designee on prompt services such as dental care and therapy weekly x 4 weeks and monthly x 1 month. Audit results will be reviewed through the monthly QAPI process/meeting.	Completion Date: **02/11/2025** Status: **APPROVED** Date: **01/28/2025**

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F 0621 SS=D	Continued from page 51 Based on a review of facility documents, and resident and staff interview, it was determined that the facility failed to not distinguish between residents based on their source of payment when providing services that are required to be provided for two of twelve residents (Resident R45, and R87). Findings Include: Review of the clinical record indicated Resident R45 was admitted to the facility on 10/2/24. Review of Resident R45's Minimum Data Set (MDS - a periodic assessment of care needs) dated 11/26/24, indicated diagnoses of high blood pressure, muscle weakness, and adult failure to thrive (seen in older adults with multiple medical conditions resulting in downward spiral of poor nutrition, weight loss, inactivity, depression, and decrease in functional abilities). Review of a physician order dated 11/26/24, indicated dental consult ASAP (as soon as	F 0621		

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F 0621 SS=D	Continued from page 52 possible), for abscess (a swollen area within body tissue, containing an accumulation of pus)/infection. Review of Resident R45's care plan dated 11/27/24, indicated the resident is on antibiotic therapy related to dental abscess. Review of a progress note dated 11/26/24, at 8:14 a.m. completed by Licensed Practical Nurse (LPN) Employee E20 stated, "During morning medication pass, noted philtrum area (space between nose and upper lip) to be swelled and tender to touch. Client opened mouth and noted a sore on the top left side of mouth. Client is able to chew food/eat/drink. Educated client if she I having difficulty eating/chewing to let staff know so diet can be changed accordingly. Alerted Nurse Practitioners/physician and provided ice for area." Review of a physician order dated 11/26/24, indicated to administer Clindamycin Phosphate 600 mg (milligrams) intravenously (through a vein) every 8 hours for dental infection for 7 days.	F 0621		

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F 0621 SS=D	Continued from page 53 Review of a progress note dated 11/29/24, completed by Certified Registered Nurse Practitioner (CRNP) Employee E6 stated, "Resident R45 seen today for follow up of dental infection, pain, and elevated blood sugar. Patient seen while resting in bed in NAD (no acute distress). Swelling to top lip much improved, no longer red or swollen. Patient reports pain is gone and she is feeling much better. IV (intravenous) antibiotics changed to PO (by mouth) for remainder of treatment. Assessment and plan for dental abscess/infection, discontinue IV start PO Clindamycin 300 mg QID (four times a day) x 5 days. Start Peridex (a germicidal mouthwash that reduces bacteria in the mouth) swish and spit mouth rinse BID (twice a day), dental consult, monitor worsening condition." Review of a progress note dated 12/2/24, completed by CRNP Employee E6 stated, "Resident R45 seen today for follow up of dental infection/abscess. Patient seen while resting in bed in NAD. She reports feeling much better. Denies any	F 0621		

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F 0621 SS=D	Continued from page 54 pain to upper lip/gum area. Swelling resolved. No difficulty eating or drinking at present. Upper gum area with small red, swollen area under lip, so symptoms of infection at present. Teeth remain decayed/chipped. Awaiting dental appointment." Review of a progress note dated 12/4/24, completed by CRNP Employee E6 stated, "Resident R45 seen today for follow up of dental abscess and diabetes. Patient seen while resting in bed in NAD. Swelling to upper lip resolved since antibiotics, now completed. Denies any further pain/discomfort. Assessment and plan for dental abscess/infection, completed Clindamycin with improvement in symptoms. Continue Peridex swish and spit mouth rinse BID. Dental consult pending for decayed teeth." Review of a physician order dated 12/18/24, indicated to administer Augmentin 875 mg-125 mg give one tablet by mouth every 12 hours for dental infection for 7 days.	F 0621		

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F 0621 SS=D	Continued from page 55 Review of a progress note dated 12/18/24, completed by CRNP Employee E7 stated, "Resident R45 seen today while resting in bed in NAD. Lab and abdominal x-ray results. Labs indicated critical blood glucose at 465 and WBC (white blood count) elevated at 12.8. Was recently treated for dental infection with current elevated WBC of 12.8. Assessment and plan for leukocytosis (elevated WBC level) possible returning dental infection, start Augmentin 875 mg-125 mg BID for 7 days until 12/25." Review of Resident R45's clinical record on 12/19/24, failed to indicate that Resident R45 received dental services as ordered. During an interview on 12/19/24, at 12:41 p.m. Ward Clerk Employee E5 stated, "The dentist is coming to the facility on January 8th, I have Resident R45 on the list to be seen. I was unable to get her an appointment anywhere outside of the facility because she was MA (medical assistance) pending at the time the dental consult order was	F 0621		

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F 0621 SS=D	Continued from page 56 written. She has insurance now. The dentist did come to the facility this month, but I was unable to put her on the list to be seen because she was MA pending." During an interview on 12/19/24, at 1:02 p.m. the Business Office Manager (BOM) Employee E8 stated, "Resident R45 was just recently approved for medical assistance. She did not have insurance coverage at the time of admission that I can recall." During an interview on 12/20/24, at 1:59 p.m. the Nursing Home Administrator (NHA) stated, "I left a message with our dental provider that comes into the facility. They stated they want payment the day of services, but we're going to have to work something out going forward". During this interview, the NHA confirmed that the facility failed to provide required services for Resident R45. Review of the clinical record revealed that Resident R87 was admitted to the facility on 11/26/24.	F 0621		

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F 0621 SS=D	Continued from page 57 Review of Resident 87's MDS dated 12/3/24, indicated diagnoses of high blood pressure, heart failure (a progressive heart disease that affects pumping action of the heart muscles), and diabetes (a disorder in which the body has high sugar levels for prolonged periods of time). Review of medical records revealed that Resident R87 had physician's orders for Physical Therapy (PT) Evaluation and Treatment as needed, and Occupational Therapy (OT) Evaluation and Treatment as needed, and a Speech Therapy (ST) Evaluation and Treatment as needed, all dated 11/26/24. Review of medical record revealed a "Rehabilitation Admission Screen" dated 11/26/24, indicated that Resident R87 was screened for PT, OT, and ST, however it was noted that Resident R87 was to be "Screened only per NHA" (Nursing Home Administrator). PT noted that Resident R87 is recommended for PT as she has had a decline in functional mobility as prior to admission she walked	F 0621		

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F 0621 SS=D	Continued from page 58 community distances without an assisted device, and now requires a front wheeled walker and is with limited distance. OT noted that Resident R87 is recommended for OT to promote activities of daily living and functional mobility and independence with positioning, seating, balance, safety, activity tolerance, general strength and decrease the risk of falls during functional tasks. High risk for falls. Wheelchair seating system recommended at this time. During an interview on 12/16/24, at 11:37 a.m. Resident R87 indicated that she had not received any therapy, as the facility was filling out her insurance paperwork. During an interview on 12/17/24, at 2:15 p.m. Rehabilitation Manager (RM) Employee E17 stated that the Resident R87 was not picked up by therapy as she did not have insurance. During an interview on 12/18/24, at 10:17 a.m. BOM Employee E8 stated that Resident R87 had	F 0621		

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F 0621 SS=D	Continued from page 59 applied for medical assistance to pay for her stay upon admission, and that this this status was "pending". BOM Employee E8 stated that it appears that she will be approved but confirmed that she has not started the therapy services that she was ordered. During an interview on 12/18/24, at 1:44 p.m. RM Employee E17 stated that Resident R87 was screened only but not started on therapy services until a payer source was obtained. During an interview on 12/18/24, at 1:46 p.m. NHA confirmed that the facility failed to administer therapy sources as ordered for Resident R87 and stated, "I just told therapy to screen her". 28 Pa Code: 201.18(e)(1) Management.	F 0621		
F 0622 SS=D		F 0622		

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F 0622 SS=D	Continued from page 60 483.15(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	MD was retroactively notified regarding change of condition for R18 and R47. Whole house audit completed to ensure no additional residents were affected. Nursing staff and social worker will be educated on sending necessary health information to a receiving health care facility when residents are transferred to an alternate setting by 2/11/2025. Audit will be conducted by DON or designee on sending necessary health information to a receiving health care facility when residents are transferred to an alternate setting weekly x 1 week and monthly x 1 month.	Completion Date: **02/11/2025** Status: **APPROVED** Date: **01/28/2025**

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F 0622 SS=D	Continued from page 61 while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose. §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i) (A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (i) Documentation in the resident's medical record must include: (A) The basis for the transfer per paragraph (c)(1)(i) of this section. (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). (ii) The documentation required by paragraph (c)(2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and	F 0622		

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(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 0622 SS=D	Continued from page 62 (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		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395471	A. BLDG: __00_____ B. WING: _____	12/20/2024

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F 0622 SS=D	Continued from page 63 Based on review of facility policy, clinical record review, and staff interview, it was determined that the facility failed to make certain that the necessary resident information was communicated to the receiving health care provider for two of two residents with facility-initiated transfers (Residents R18 and R47). Findings include: Review of facility policy "Transfer and Discharge (Including AMA)" dated 12/3/24, indicated for a transfer to another provider, for any reason, the following information must be provided to the receiving provider: contact information of the practitioner who was responsible for the care of the resident, resident representative information including contact information, advice director information, all other information necessary to meet the resident's needs, which includes but is not limited to resident status, diagnoses and allergies, medications, most recent relevant labs, diagnostic tests, treatments, special risks, and the resident's	F 0622		

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 0622 SS=D	Continued from page 64 comprehensive care plan. Review of the clinical record indicated Resident R18 was admitted to the facility on 11/24/23. Review of Resident R18's Minimum Data Set (MDS - a periodic assessment of care needs) dated 11/13/24, indicated diagnoses of high blood pressure, hyperlipidemia (high levels of fat in the blood), and dependence on supplemental oxygen. Review of Resident R18's clinical record revealed that the resident was transferred to the hospital on 12/6/24. Review of Resident R18's clinical record revealed no documented evidence that the facility had communicated specific information to the receiving health care provider for the residents transferred and expected to return, which included the resident's care plan goals, advanced directive information, specific instructions for ongoing care, resident representative information, and all information	F 0622		

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F 0622 SS=D	Continued from page 65 necessary to meet the resident's specific needs at the receiving facility. Review of Resident R47's admission record indicated the resident was admitted to the facility 3/10/23. Review of Resident R47's MDS dated 11/8/24, included diagnoses of depression, diabetes (a metabolic disorder in which the body has high sugar levels for prolonged periods of time), and hyperlipidemia (a high level of fat particles in the blood). Review of Resident R47's clinical record revealed that the resident was transferred to the hospital on 4/16/24. Review of Resident R47's clinical record revealed no documented evidence that the facility had communicated specific information to the receiving health care provider for the residents transferred and expected to return, which included the resident's	F 0622		

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 0622 SS=D	Continued from page 66 care plan goals, advanced directive information, specific instructions for ongoing care, resident representative information, and all information necessary to meet the resident's specific needs at the receiving facility. During an interview on 12/20/24, at 1:38 p.m. the Director of Nursing confirmed that the facility failed to make certain that the necessary resident information was communicated to the receiving health care provider for two of two residents as required. 28 Pa. Code 201.29 (a) (c.3) (2) Resident rights.	F 0622		
F 0625 SS=E		F 0625		

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 0625 SS=E	Continued from page 67 483.15(d)(1)(2) Notice of Bed Hold Policy Before/Upon Trnsfr §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by:	F 0625	Resident R17, R18 and R47 suffered no ill effects regarding bed hold policy. Education on the bed hold policy will be provided to nurses by DON or designee on or before 2/11/2025. Audits will be conducted by the DON or designee to ensure the bed hold policy process is being followed 3 x a week x 4 weeks and monthly X 1 month. Audit results will be reviewed through the monthly QAPI process/meeting.	Completion Date: **02/11/2025** Status: **APPROVED** Date: **01/28/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0625 SS=E	Continued from page 68	F 0625		

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F 0625 SS=E	Continued from page 69 Based on review of facility policy, clinical record review, and staff interviews, it was determined that the facility failed to notify the resident or resident's representative of the facility bed-hold policy (an agreement for the facility to hold a bed for an agreed upon rate during a hospitalization) for three of three resident hospital transfers (Residents R17, R18, and R47). Findings include: Review of facility policy "Transfer and Discharge (Including AMA)" dated 12/3/24, indicated during an emergency transfer/discharge, the facility will provide a notice of transfer and the facility's bed hold policy to the resident and representative as indicated. Review of the clinical record indicated that Resident R17 was admitted to the facility on 7/25/24. Review of the Minimum Data Set (MDS - a periodic assessment of care needs) dated 8/1/24,	F 0625		

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F 0625 SS=E	Continued from page 70 indicated diagnoses of Chronic Obstructive Pulmonary Disease (an ongoing lung condition caused by damage to the lungs), Obstructive Sleep Apnea (a sleep disorder in which the throat muscles relax and block the airway, causing breathing to become restricted and briefly stop), and respiratory failure. Review of Resident R17's clinical record revealed the resident was transferred out to the hospital on the following dates: -9/9/24 -9/15/24 -9/18/24 -9/28/24 -10/30/24 Review of Resident R17's clinical record failed to include documented evidence that the resident or the resident's representative were provided with written information about the facility's bed hold policy at the time of the transfer to the hospital on the following dates:	F 0625		

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F 0625 SS=E	Continued from page 71 -9/9/24 -9/15/24 -9/18/24 -9/28/24 -10/30/24 Review of the clinical record indicated Resident R18 was admitted to the facility on 11/24/23. Review of Resident R18's MDS dated 11/13/24, indicated diagnoses of high blood pressure, hyperlipidemia (high levels of fat in the blood), and dependence on supplemental oxygen. Review of Resident R18's clinical record revealed that the resident was transferred to the hospital on 12/6/24. Review of Resident R18's clinical record failed to include documented evidence that the resident or the resident's representative were provided with written information about the facility's bed hold policy at the time of the transfer to the hospital on 12/6/24.	F 0625		

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F 0625 SS=E	Continued from page 72 Review of Resident R47's admission record indicated the resident was admitted to the facility 3/10/23. Review of Resident R47's MDS dated 11/8/24, included diagnoses of depression, diabetes (a metabolic disorder in which the body has high sugar levels for prolonged periods of time), and hyperlipidemia (a high level of fat particles in the blood). Review of Resident R47's clinical record revealed that the resident was transferred to the hospital on 4/16/24. Review of Resident R47's clinical record failed to include documented evidence that the resident or the resident's representative were provided with written information about the facility's bed hold policy at the time of the transfer to the hospital on 4/16/24. During an interview on 12/20/24, at 1:38 p.m. the	F 0625		

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 0625 SS=E	Continued from page 73 Director of Nursing confirmed that the facility failed to notify the resident or resident's representative of the facility bed-hold policy for three of three resident hospital transfers (Residents R17, R18, and R47). 28 Pa. Code 201.29 (a) (c.3) (2) Resident rights.	F 0625		
F 0641 SS=E		F 0641		

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F 0641 SS=E	Continued from page 74 483.20(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	RNAC made immediate modifications to the prior MDS assessments to correct for discrepancies for R1, R17, and R91. An immediate whole house audit was conducted to ensure MDS are accurate. Education was provided to the RNAC, and RN supervisors by the DON or designee on the importance of correctly entering the diagnosis on the resident's chart upon admission. Audits will be completed by the DON or designee on accuracy of diagnosis and place of discharge during AM clinical weekly x four weeks and monthly x 1 month of all new admissions to compare the diagnosis from the medical records received upon admission to those entered in the EMAR to ensure accuracy. Audit results will be reviewed through the monthly QAPI process/meeting.	Completion Date: **02/11/2025** Status: **APPROVED** Date: **01/28/2025**

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F 0641 SS=E	Continued from page 75 Based on a review of the RAI (Resident Assessment Instrument), clinical records, and staff interviews it was determined that the facility failed to make certain that resident assessments were accurate for three of twelve residents (Residents R1, R17, and R91). 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 the following: Section A1500: Preadmission Screening and Resident Review (PASRR): code 1, yes if: PASSR Level II screening determined that the resident has a serious mental illness and/or ID/DD (Intellectual Disability/Developmental Disability) or related condition, and continue to A1510, Level II Preadmission Screening and Resident Review (PASRR) Conditions.	F 0641		

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F 0641 SS=E	Continued from page 76 Section A2105: Discharge Status: This item documents the location to which the resident is being discharged at the time of discharge. Select the two-digit code that corresponds to the resident's discharge status. Code 01, Home/Community: if the resident was discharged to a private home, apartment, board and care, assisted living facility, group home, transitional living, or adult foster care. A community residential setting is defined as any house, condominium, or apartment in the community, whether owned by the resident or another person. Section O0110G2: Special Treatments, procedures, and Programs: Check if resident received BiPAP (a device that helps to breathe). Review of the clinical record revealed Resident R1 was admitted to the facility on 2/27/23. Review of Resident R1's MDS dated 11/28/24, indicated diagnoses of anxiety (a feeling of worry,	F 0641		

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F 0641 SS=E	Continued from page 77 nervousness, or unease), Schizoaffective disorder (a mental health condition marked by a mix of schizophrenia symptoms, such as hallucinations and delusions, and a mood disorder symptoms, such as depression and mania), and anoxic brain damage (occurs when the brain is deprived of oxygen, leading to damage or deal of brain cells). Review of Resident R1's admission MDS dated 3/6/23, Question A1500 Preadmission Screening and Resident Review (PASRR) indicated "yes" the resident is currently considered by the state Level II PASRR process to have a serious mental illness and/or intellectual disability or a related condition. Review of Resident R1's annual comprehensive MDS dated 2/13/24, Question A1500 Preadmission Screening and Resident Review (PASRR) indicated "no" the resident is not currently considered by the state level II PASRR process to have a serious mental illness and/or intellectual disability or a related condition.	F 0641		

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F 0641 SS=E	Continued from page 78 During an interview on 12/19/24, at 11:54 a.m. Registered Nurse Assessment Coordinator (RNAC) Employee E2 stated, "I checked with Social Work and once a resident is determined to be a Level II, it does not change, the annual MDS should have been coded as yes." During an interview on 12/19/24, at 11:54 a.m. RNAC Employee E2 confirmed that the facility failed to make certain that resident assessments were accurate for Resident R1. Review of the clinical record indicated that Resident R17 was admitted to the facility on 7/25/24. Review of Resident R17's MDS dated 11/15/24, indicated diagnoses of Chronic Obstructive Pulmonary Disease (an ongoing lung condition caused by damage to the lungs), Obstructive Sleep Apnea (a sleep disorder in which the throat muscles relax and block the airway, causing breathing to become restricted and briefly stop), and respiratory failure. Section O-Special Treatments, Procedures,	F 0641		

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F 0641 SS=E	Continued from page 79 and Programs C1. Oxygen Therapy and G1. Non-invasive Mechanical Ventilator was not checked and failed to indicate the resident was receiving oxygen and BIPAP therapy. Review of Resident R17's active physician order dated 7/28/24, indicated to administer 2L oxygen continuously, every shift for oxygen therapy. Review of Resident R17's physician order dated 10/7/24, entered by Nurse Practitioner, Employee E7 indicated the resident is to wear BIPAP (a mechanical breathing device that uses positive pressure ventilation to treat sleep apnea and other health conditions that affect your breathing) at night and any time during the day when sleeping. The settings were 12/8 with 4L oxygen. During an interview on 12/20/24, at 12:18 p.m. the Director of Nursing confirmed the facility failed to make certain that resident assessments were accurate for Resident R17.	F 0641		

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	395471	A. BLDG: 00 B. WING:	12/20/2024

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F 0641 SS=E	Continued from page 80 Review of the admission record indicated Resident R91 was admitted to the facility on 10/17/24. Review of Resident R91's MDS dated 10/22/24, indicated the diagnoses of anemia (too little iron in the body causing fatigue), high blood pressure, and dementia (a group of symptoms that affects memory, thinking and interferes with daily life). Section A2105 was entered as 04, which indicated that resident R91 was discharged to a Short-Term General Hospital. Review of progress notes dated 11/1/24, indicated that Resident R91 was discharged to home with family. During an interview on 12/17/24, at 10:01 a.m. RNAC Employee E2 confirmed the facility failed to make certain that resident assessments were accurate for Resident R91. 28 Pa. Code: 211.12(d)(1)(2)(3)(5) Nursing Services.	F 0641		

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F 0641 SS=E	Continued from page 81	F 0641		
F 0679 SS=E	483.24(c)(1) Activities Meet Interest/Needs Each Resident §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by:	F 0679	The activities calendar was revised to provide alternative activities when COVID is active in the building. A full-time activities staff was hired. A review will be completed of resident activity preferences to determine likes/preferences. Activity calendar will be approved by NHA or designee and reviewed before being circulated. A discussion will be held during the upcoming resident council regarding details of evening activities and the need for modifications. Education on activity programs will be provided to the Activities Director by the NHA or designee on or before 2/11/2025. Audits will be conducted on activities to ensure scheduled activities are being followed by DON or designee weekly x 4 weeks and monthly x 1 month. Audit results will be reviewed through the monthly QAPI process/meeting.	Completion Date: **02/11/2025** Status: **APPROVED** Date: **01/28/2025**

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F 0679 SS=E	Continued from page 82 Based on a review of the clinical record, resident council group, and staff interviews, it was determined that the facility failed to provide an ongoing program of activities to meet the interests of and support the physical, mental, and psychosocial well-being of each resident for four of four weeks (December 2024). Findings include: Review of facility policy "Activities" dated 12/3/24, indicated the facility is to provide an ongoing program to support residents in their choice of activities. Facility group, individual, and independent activities will be designed to meet the interest of each resident, as well as support their physical, mental, and psychosocial well-being. Activities will include individual, small, and large group activities. Activities will be designed with the intent to; - Enhance the resident's sense of well-being, belonging, and usefulness. - Create opportunities of each resident to have a	F 0679		

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F 0679 SS=E	Continued from page 83 meaningful life. - Promote or enhance physical activity. - Promote or enhance cognition. - Promote or enhance emotional health. - Promote self-esteem, dignity, pleasure, comfort, education, creativity, success, and independence. - Reflect residents ' interests and age. - Reflect cultural and religious interest of the residents. - Reflect choices of the residents. During an interview on 12/16/24, at 10:03 a.m. Activity Director Employee E18 stated "We are not having group activities because we have positive COVID-19 in the building". During resident group on 12/17/24, at 1:30 p.m. four out of seven residents voiced concerns that the activities don't always meet their needs. Residents stated that the activity calendar can change, and activities don't take place, and they are unaware of when the changes are going to take place. Resident stated, "I ' ve sat here waiting for an activity for	F 0679		

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F 0679 SS=E	Continued from page 84 awhile and then they will come in to tell me that its cancelled" and "BINGO has been cancelled for four weeks in a row now". During resident group on 12/17/24, at 1:37 p.m. residents indicated that they would like to have group activities and that the only evening activity is on Thursdays. Resident stated, "Evening activities would give us something to do". A review of facility activity calendar dated December 2024, indicated that activities are scheduled until 3:00 p.m. and no evening activities are scheduled except for Thursdays. A review of facility activity calendar dated December 2024, indicated that activites are subject to change without notice. During an interview on 12/20/24, at 10:13 a.m. Activities Director Employee E18 confirmed that the facility failed to provide an ongoing program of activities to meet the interests of and support the	F 0679		

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F 0679 SS=E	Continued from page 85 physical, mental, and psychosocial well-being of each resident for four of four weeks (December 2024). 28 Pa. Code: 201. 18(b)(3) Management. 28 Pa. Code: 207.2(a) Administrators Responsibility.	F 0679		
F 0684 SS=E		F 0684		

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F 0684 SS=E	Continued from page 86 483.25 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	Meeting held with pharmacy to discuss process when medications are not delivered, re-training provided to NHA, ADON, and Unit Manager and additional pharmacy system access provided. Meeting held with MD and NP by NHA regarding streamlining process. Modifications made to morning clinical meeting. Discussion held with NP regarding R17 regarding any changes and R45 and R47 regarding blood glucose measurements. Charts were reviewed retroactively for R17, R45, and R47. An audit was completed on like residents on 1/9/2025 to ensure there were no additional medication issues and notification to physicians were occurring timely for missed medications and blood sugar issues. Parameters were implemented retroactively for blood sugars. An appointment was immediately made for a neurology appointment with an alternative physician for R50. An appointment was immediately made for a colonoscopy for R53. Education was provided to the	Completion Date: **02/11/2025** Status: **APPROVED** Date: **01/28/2025**

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F 0684 SS=E	Continued from page 87	F 0684	RNAC, ADON, unit manager and RN supervisors by the DON or designee on notification to physicians, hypoglycemia management, medication administration, blood glucose monitoring, and resident rights,and prompt appointments for outside consults on or before 2/11/2025. Audits will be completed by the DON or designee on prompt appropriate treatment and care during AM clinical 3 times a week x four weeks and monthly x 1 month. Audit results will be reviewed through the monthly QAPI process/meeting.	

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F 0684 SS=E	Continued from page 88 Based on review of facility policy, clinical record review, and staff interviews, it was determined that the facility failed to make certain that residents were provided appropriate treatment and care for five of 20 residents (Residents R17, R45, R47, R50, and R53). Findings include: Review of facility policy "Hypoglycemia Management" dated 12/3/24, indicated if the blood glucose reading is 70 mg/dL (milligram per deciliter) or below, the nurse will utilize the hypoglycemic protocol as per the practitioner's orders, with follow up blood glucoses as indicated, and notify the practitioner of the results as ordered. 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	F 0684		

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F 0684 SS=E	Continued from page 89 sugar goes up, it signals your pancreas to release insulin. Insulin acts like a key to let the blood sugar into your body's cells for use as energy. If you have diabetes, your body either doesn't make enough insulin or can't use the insulin it makes as well as it should. When there isn't enough insulin or cells stop responding to insulin, too much blood sugar stays in 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 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	F 0684		

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F 0684 SS=E	Continued from page 90 hyperglycemia and it's untreated for long periods of time, you can damage your nerves, blood vessels, tissues and organs. Damage to blood vessels can increase your risk of heart attack and stroke, and nerve damage may also lead to eye damage, kidney damage and non-healing wounds. Review of facility policy "Medication Administration" dated 12/3/24, indicated medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection. Review MAR (Medication Administration Record) to identify medication to be administered. Review of facility policy "Blood Glucose Monitoring" dated 12/3/24, indicated that facility is to perform blood glucose monitoring to diabetic residents as per physician's orders. Report critical test results to physician timely.	F 0684		

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F 0684 SS=E	Continued from page 91 The facility policy "Resident rights" reviewed 12/3/24, indicated that the facility will support and facilitate a resident ' s right to request, refuse, and discontinue medical or surgical treatment. The facility will provide the resident information in a manner that is easy to understand. Review of the clinical record indicated that Resident R17 was admitted to the facility on 7/25/24, with diagnoses of depression, anxiety, and insomnia (difficulty falling and/or staying asleep), and bipolar (a serious mental illness characterized by extreme mood swings. They can include extreme excitement episodes or extreme depressive feelings). Review of Resident R17's MDS dated 8/1/24, indicated the diagnoses were current. Review of Resident R17's physician order dated 10/7/24, indicated to administer one capsule of 50 milligrams (mg) of Doxepin (an antidepressant medication used to treat depression, anxiety, and insomnia) at bedtime for bipolar disorder and	F 0684		

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F 0684 SS=E	Continued from page 92 depression. Review of Resident R17's care plan dated 10/28/24, indicated the resident uses antidepressant and psychotropic medications medication due to depression and bipolar. Interventions indicated to administer medications as ordered by physician, consult with pharmacy and physician to consider dosage reduction when clinically appropriate. Review of Resident R17's November 2024 Medication Administration Record (MAR) revealed 13 missed doses on the following dates. -11/12/24 "Not administered, awaiting delivery from Pharmacy." -11/14/24 "Per pharmacy, on order. Awaiting pharmacy deliver." -11/15/24 "Awaiting delivery from Pharmacy." -11/17/24 "Per pharmacy, on order." -11/18/24 "Per pharmacy, on order." -11/19/24 "Per pharmacy this remains on order." -11/20/24 "Unavailable" -11/21/24 "MD notified pharmacy called, waiting	F 0684		

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F 0684 SS=E	Continued from page 93 for delivery." -11/22/24 "Awaiting delivery from pharmacy." -11/25/24 "On order at pharmacy." -11/26/24 "On order at pharmacy." -11/27/24 "On order at pharmacy." -11/28/24 "Waiting on pharmacy." Review of Resident R17's December 2024 MAR revealed two missed doses on the following dates. -12/1/24 "Medications not here." -12/5/24 'Remains on order from pharmacy." During an interview on 12/19/24, at 9:57 a.m. Resident R17 stated he was not receiving his Doxepin for a while. During an interview on 12/20/24, at 9:24 a.m. the Assistant Director of Nursing, Employee E14 confirmed Resident R17's Doxepin was not available or dispensed from the facility from 11/12/24, through 12/5/24. ADON, Employee E14 confirmed the facility failed to administer Resident R17's Doxepin as ordered.	F 0684		

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F 0684 SS=E	Continued from page 94 Review of the clinical record indicated Resident R45 was admitted to the facility on 10/2/24. Review of Resident R45's MDS dated 11/26/24, indicated diagnoses of high blood pressure, diabetes, and adult failure to thrive (seen in older adults with multiple medical conditions resulting in downward spiral of poor nutrition, weight loss, inactivity, depression, and decrease in functional abilities). Review of Resident R45's care plan dated 10/16/24, indicated the resident has diabetes and to monitor/document/report to physician as needed signs and symptoms of hypo- and hyperglycemia. Review of Resident R45's vitals record for November 2024, indicated the following blood glucose measurements: 11/12/24 at 8:09 a.m. 50 mg/dL 11/13/24 at 7:28 a.m. 64 mg/dL	F 0684		

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F 0684 SS=E	Continued from page 95 11/13/24 at 4:55 p.m. 57 mg/dL 11/16/24 at 8:19 a.m. 59 mg/dL 11/16/24 at 12:07 p.m. 58 mg/dL 11/28/24 at 3:50 p.m. 431 mg/dL 11/28/24 at 8:54 p.m. 456 mg/dL 11/30/24 at 4:56 p.m. 66 mg/dL Review of Resident R45's progress notes from 11/1/24, through 11/30/24, failed to include documentation that the physician was made aware of Resident R45's abnormal blood glucose readings on the dates listed above. Review of a physician order dated 12/16/24, indicated to administer Lantus (a long-acting insulin) inject 40 units subcutaneously (under the skin into the fatty tissue layer) at bedtime for diabetes. Hold if less than 80 blood sugar. Review of a Medication Administration Note dated 12/18/24, at 10:55 p.m. completed by Licensed Practical Nurse (LPN) Employee E19 stated, "Lantus held, blood sugar 206. Resident did not	F 0684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395471	A. BLDG: __00_____ B. WING: _____	12/20/2024

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F 0684 SS=E	Continued from page 96 eat." Review of Resident R45's progress notes from 12/18/24, to 12/19/24, failed to include documentation that the physician was made aware of Resident R45 not eating. Review of the documentation also failed to include an order from the physician to hold Resident R45's scheduled Lantus dose. During an interview on 12/19/24, at 10:55 a.m. the Director of Nursing (DON) confirmed that the facility failed to notify the physician of Resident R45's abnormal blood glucose readings and held a medication without a physician order. During this interview, the DON confirmed that the facility failed to make certain that Resident R45 was provided appropriate treatment and care. Review of Resident R47's admission record indicated the resident was admitted to the facility 3/10/23.	F 0684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0684 SS=E	Continued from page 97 Review of Resident R47's MDS dated 11/8/24, included diagnoses of depression, diabetes (a metabolic disorder in which the body has high sugar levels for prolonged periods of time), and hyperlipidemia (a high level of fat particles in the blood). Review of Resident R47's care plan dated 12/16/24, indicated the resident has diabetes and to monitor/document/report to physician as needed signs and symptoms hyperglycemia. Review of Resident R47's vitals record for December 2024, indicated the following blood glucose measurements: 12/1/24 at 8:53 p.m. 422 mg/dL 12/3/24 at 8:00 p.m. 369 mg/dL 12/4/24 at 7:43 p.m. 360 mg/dL 12/7/24 at 7:13 p.m. 443 mg/dL 12/8/24 at 6:05 p.m. 438 mg/dL 12/8/24 at 8:10 p.m. 389 mg/dL 12/9/24 at 7:20 p.m. 365 mg/dL	F 0684		

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F 0684 SS=E	Continued from page 98 12/10/24 at 5:09 p.m. 388 mg/dL 12/10/24 at 9:41 p.m. 378 mg/dL 12/11/24 at 4:37 p.m. 385 mg/dL 12/11/24 at 7:01 p.m. 371 mg/dL 12/14/24 at 7:43 p.m. 375 mg/dL 12/16/24 at 4:31 p.m. 406 mg/dL Review of Resident R47's progress notes from 12/1/24, through 12/16/24, failed to include documentation that the physician was made aware of Resident R47's abnormal blood glucose readings on the dates listed above. Review of a physician order dated 12/10/24, indicated to administer Humalog (a short acting insulin) three units. Hold is blood sugar is less than 100, wait until food in front of to make sure eating. Review of a physician order dated 12/14/24, indicated Lantus (a long-acting insulin) ten units in the morning. No parameters are given as to when to notify physician.	F 0684		

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F 0684 SS=E	Continued from page 99 During an interview on 12/19/24, at 11:05 a.m. the Director of Nursing confirmed above findings and that the facility did not notify physician of abnormal blood glucose readings for Resident R47. Review of Resident R50's clinical record indicated the resident was admitted to the facility on 8/23/23. Review of Resident R50's MDS dated 11/9/24, indicated diagnoses of high blood pressure, seizure disorder (a disorder in which nerve cell activity in the brain is disturbed), and depression. Review of Resident R50's physician orders dated 4/3/24, indicated to schedule resident a neurology appointment due to possible seizures. Review of Resident R50's clinical record on 12/18/24, at 11:33 a.m. failed to have neurology appointment records to review. During an interview on 12/18/24, at 2:15 p.m. Ward Clerk Employee E5 stated, "I tried making an	F 0684		

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F 0684 SS=E	Continued from page 100 appointment and the physician office declined taking the resident due to past noncompliance with medical appointments prior to admission and referred me to another office. I did not call and set up that appointment". During an interview on 12/18/24, at 2:32 p.m. Ward Clerk Employee E5 confirmed that the facility failed to make an appointment per physician order for Resident R50. Review of Resident R53's clinical record indicated the resident was admitted to the facility on 12/24/19. Review of Resident R53's MDS dated 10/11/24, indicated diagnoses of high blood pressure, diabetes (a metabolic disorder in which the body has high sugar levels for prolonged periods of time), and dementia (a group of symptoms that affects memory, thinking and interferes with daily life). Review of Resident R53's physician orders dated	F 0684		

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F 0684 SS=E	Continued from page 101 2/11/24, indicated to schedule resident a screening colonoscopy. Review of Resident R53's clinical record on 12/18/24, at 10:33 a.m. failed to have colonoscopy records to review. During an interview on 12/20/24, at 11:43 a.m. Ward Clerk Employee E5 stated, "He hasn't gotten a colonoscopy yet. I haven't scheduled it". During an interview on 12/20/24, at 11:50 a.m. Ward Clerk Employee E5 confirmed that the facility failed to make an appointment per physician order for Resident R53. 28 Pa. Code 201.18 (b)(1) Management 28 Pa. Code 201.29(a) Resident Rights 28 Pa. Code 211.10 (c)(d) Resident Care policies 28 Pa. Code 211.12 (d)(1)(2)(3)(5) Nursing services	F 0684		

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F 0689 SS=D	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by:	F 0689	R8 care plan was updated to indicate that she wants to keep wanderguard but it is not in activation status. Management will continue to approach resident regarding returning wanderguard. R53 care plans were updated to delete wanderguards. Elopement assessments updated. Updated assessments on all residents have been completed. R8's wanderguard will be de-activated as it is not needed, per assessment but she is not willing to surrender it. Like residents were audited to ensure no other care plans or wanderguards needed modifications. Education will be provided to the RNAC, Nurses and nursing management on wanderguard placement on or before 2/11/2025. Audits on wanderguards assessments be completed timely will be completed by the DON or designee weekly x 4 weeks and monthly x 1 month. Audit results will be reviewed through the monthly QAPI process/meeting.	Completion Date: **02/11/2025** Status: **APPROVED** Date: **01/28/2025**

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F 0689 SS=D	Continued from page 103 Based on review of facility policy, clinical records, resident, and staff interviews, it was determined that the facility failed to complete quarterly wander guard (a device that triggers alarms when close to an exit) assessments for two of two residents (Resident R8, and Resident R53). Findings include: Review of facility "Elopements and Wandering Residents" policy dated 12/3/24, indicated that the facility ensures that residents who exhibit wandering behavior and at risk for elopement receive adequate supervision to prevent accidents, and receive care in accordance with their person-centered plan of care addressing the unique factors contributing to wandering or elopement risk. Residents will be assessed for risk of elopement and unsafe wandering upon admission and throughout their stay. Review of Resident R8's clinical record indicated the resident was admitted to the facility on 12/23/22.	F 0689		

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F 0689 SS=D	Continued from page 104 Review of Resident R8's MDS (Minimum Data Set, periodic assessment of resident care needs) dated 10/2/24, indicated diagnoses of high blood pressure, arthritis, and diabetes (a metabolic disorder in which the body has high sugar levels for prolonged periods of time). Restraint and Alarm Section P0200 wander-elopement alarm is coded. Review of Resident R8's plan of care, as of 1/4/24, indicated Resident R8 will wear a wander guard. Check placement every shift. Check function daily on night shift. Review of Resident R8's clinical record on 12/19/24, at 10:55 a.m. revealed that Resident R8's last elopement assessment was completed on 7/1/24. Review of Resident R53's clinical record indicated the resident was admitted to the facility on 12/24/19.	F 0689		

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F 0689 SS=D	Continued from page 105 Review of Resident R53's MDS dated 10/11/24, indicated diagnoses of high blood pressure, diabetes (a metabolic disorder in which the body has high sugar levels for prolonged periods of time), and dementia (a group of symptoms that affects memory, thinking and interferes with daily life). Restraint and Alarm Section P0200 wander-elopement alarm is coded. Review of Resident R53's plan of care, as of 1/2/24, indicated Resident R53 will wear a wander guard. Check placement every shift. Check function daily on night shift. Review of Resident R53's clinical record on 12/19/24, at 10:58 a.m. revealed that Resident R53's last elopement assessment was completed on 5/3/24. During an interview on 12/19/24, at 1:33 p.m. Registered Nurse Employee E14 confirmed that the facility failed to complete quarterly wander guard (a device that triggers alarms when close to an exit)	F 0689		

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F 0689 SS=D	Continued from page 106 assessments for two of two residents (Resident R8, and Resident R53). 28 Pa. Code 201.14(a) Responsibility of licensee. 28 Pa. Code 201.18(b)(1)(e)(1) Management. 28 Pa. Code 211.10(c)(d) Resident care policies. 28 Pa. Code 211.12(d)(1)(2)(3)(5) Nursing services.	F 0689		
F 0690 SS=D		F 0690		

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F 0690 SS=D	Continued from page 107 483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.	F 0690	R36 suffered no ill effects from not receiving constipation management from 12/6/24 to 12/10/24. Care plan reviewed and updated as needed. Cited care plan reviewed and updated as needed. An audit was completed on like residents to ensure there were no additional issues. Education will be provided to the RNAC, Nurses and nursing management on constipation management on or before 2/11/2025. Audits will be completed on following bowel protocol by the DON or designee weekly x 4 weeks and monthly x 1 month. Audit results will be reviewed through the monthly QAPI process/meeting.	Completion Date: **02/11/2025** Status: **APPROVED** Date: **01/28/2025**

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F 0690 SS=D	Continued from page 108 This REQUIREMENT is not met as evidenced by:	F 0690		

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F 0690 SS=D	Continued from page 109 Based on review of facility policy, clinical records, and staff interview, it was determined that the facility failed to make certain that residents were provided appropriate treatment and services to maintain bowel function for one two residents (Resident R36). Findings include: Review of facility policy "Medication Administration" dated 12/3/24, indicated medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection. Review MAR (Medication Administration Record) to identify medication to be administered. Review of the clinical record indicated Resident R36 was admitted to the facility on 10/25/24. Review of Resident R36's Minimum Data Set	F 0690		

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F 0690 SS=D	Continued from page 110 (MDS - a periodic assessment of care needs) dated 11/1/24, indicated diagnoses of high blood pressure, muscle wasting, and Post Traumatic Stress Disorder (PTSD - a disorder in which a person has difficulty recovering after experiencing or witnessing a terrifying event and may have triggers that can bring back memories of trauma accompanied by intense emotional and physical reactions). Review of a physician order dated 10/25/24, indicated to administer Milk of Magnesia 30 mL (milliliters) by mouth as needed for constipation, give if no bowel movement in 48 hours. Review of a physician order dated 10/25/24, indicated to administer a Dulcolax suppository 10 mg (milligrams) rectally as needed for constipation if Milk of Magnesia is ineffective. Review of a physician order dated 11/14/24, indicated to administer Miralax 17 gm give one packet by mouth every 24 hours as needed for constipation.	F 0690		

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F 0690 SS=D	Continued from page 111 Review of Resident R36's care plan on 12/20/24, failed to indicate goals and interventions related to constipation management. Review of Resident R36's bowel record for December 2024 revealed: - No bowel movement from 12/6/24, day shift until 12/10/24, evening shift; four days, 13 shifts with no bowel movement. Review of Resident R36's December 2024 MAR indicated the following: - Dulcolax suppository was not administered. - Milk of Magnesia administered 12/10/24, at 5:37 a.m. - Miralax not was administered. Review of progress note dated 12/10/24, at 3:51 p.m. indicated that Resident R36 was given 30 mL of Milk of Magnesia. The note further indicated that the Milk of Magnesia was effective and Resident R36 had a large bowel movement.	F 0690		

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F 0690 SS=D	Continued from page 112 During an interview on 12/20/24, at 12:50 p.m. the Director of Nursing (DON) stated that the facility does not have a bowel protocol and that the facility failed to follow physician orders and administer medications as ordered. During an interview on 12/20/24, at 12:50 p.m. the DON confirmed that the facility failed to make certain that residents were provided appropriate treatment and services to maintain bowel function for one two residents as required. 28 Pa Code: 201.14 (a) Responsibility of licensee. 28 Pa. Code 201.29(a)(c)(d)(j) Resident Rights. 28 Pa code: 211.10 (c)(d) Resident care policies. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services.	F 0690		
F 0691 SS=D		F 0691		

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F 0691 SS=D	Continued from page 113 483.25(f) Colostomy, Urostomy, or Ileostomy Care §483.25(f) Colostomy, urostomy,, or ileostomy care. The facility must ensure that residents who require colostomy, urostomy, or ileostomy services, receive such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences. This REQUIREMENT is not met as evidenced by:	F 0691	Resident R39's ostomy was immediately changed, care plan was updated. Like resident's ostomy orders were audited. Care plans were audited for like residents. Education was provided to licensed nursing staff by DON or designee on ensuring that all residents with ostomy orders include the following the frequency of changes for the ostomy. Audits will be completed by DON or designee on ostomy care in AM clinical 3 times weekly for 4 weeks and monthly x 1 month. Audit results will be reviewed through the monthly QAPI process/meeting.	Completion Date: **02/11/2025** Status: **APPROVED** Date: **01/28/2025**

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F 0691 SS=D	Continued from page 114 Based on facility policy review, clinical record review, resident, and staff interviews, it was determined that the facility failed to provide colostomy care and services consistent with professional standards of practice for one of two residents reviewed (Resident R39). Findings include: Review of facility policy "Ostomy Care-Colostomy, Urostomy, and Ileostomy" dated 12/3/24, indicated it is the facility policy to ensure that residents who require colostomy (a stoma that has been constructed by connecting a part of the colon onto the anterior abdominal wall) services receive care consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences. Ostomy care will be provided by licensed nurses under the orders of the attending physician. Review of the clinical record indicated that Resident R39 was admitted to the facility on 6/19/23, with	F 0691		

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F 0691 SS=D	Continued from page 115 diagnoses of overactive bladder and kidney disease. Review of the Minimum Data Set (MDS - a periodic assessment of care needs) dated 10/28/24, indicated the diagnoses were current. Review of Resident R39's care plan dated 1/25/24, failed indicated to change the resident's ostomy (any type of surgically created opening of the gastrointestinal tract for discharge of body waste) appliance every seven days and as needed. Review of Resident R39's physician orders dated 1/26/24, indicated to change ostomy appliance every 3 days and as needed with a 2.75-inch wafer and bag. During an interview on 12/16/24, at 10:48 a.m. Resident R39 indicated her ostomy appliance was changed last Wednesday, 5 days ago. Review of Resident R39's clinical record on 12/16/24, at 11:53 a.m. failed to indicate the	F 0691		

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F 0691 SS=D	Continued from page 116 resident's care plan was updated to reflect the current physician order to change the ostomy device every three days and as needed. Review of Resident R39's December 2024 Treatment Administration Record (TAR) failed to indicate Resident R39's ostomy appliance was changed as ordered on 12/15/24. During an interview on 12/17/24, at 9:17 a.m. Licensed Practical Nurse, Employee E15 confirmed Resident R39's ostomy appliance was not changed as ordered. LPN, Employee E15 indicated if a treatment is completed then it is signed off in the electronic record on the TAR. Interview on 12/17/24, at 9:44 a.m. the Nursing Home Administrator confirmed the facility failed to provide colostomy care and services consistent with professional standards of practice for one of three residents reviewed (Resident R39). 28 Pa. Code: 201.18 (b) (1) (e) (1) Management.	F 0691		

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F 0691 SS=D	Continued from page 117 28 Pa. Code: 211.10(c)(d) Resident care policies. 28 Pa. Code: 211.12(d)(1)(5) Nursing services.	F 0691		
F 0695 SS=D	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	R17's BIPAP was immediately cleaned, and filter was changed. Resident education also provided. Observation of all respiratory equipment completed to ensure proper cleaning, dating and storage use. Like residents' machines were visually assessed and changes made as needed. Education was immediately provided to nursing staff and will be completed on the importance of regular maintenance and correct usage by DON or designee on or before 2/11/2025. This education includes proper cleaning, dating, and storage of equipment. Audits will be completed on proper storage, cleanliness, orders, care plans, dating and storage by DON or designee 3 times weekly for 4 weeks and monthly x 1 month. Audit results will be reviewed through the monthly QAPI process/meeting.	Completion Date: **02/11/2025** Status: **APPROVED** Date: **01/28/2025**

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F 0695 SS=D	Continued from page 118 Based on review of facility policies, observations, clinical record review, and staff, resident, and family interviews, it was determined that the facility failed to provide appropriate respiratory care for one of three residents (Residents R17). Findings include: Review of the facility policy "Noninvasive Ventilation" dated 12/3/24, indicated it is the policy of the facility to provide non-invasive ventilation as per physician orders and current standards of practice. The facility will obtain an order for the use of a BIPAP (a mechanical breathing device that uses positive pressure ventilation to treat sleep apnea and other health conditions that affect your breathing) device and settings from the practitioner. If a resident's personal BIPAP device is brought into the facility, the nurse/respiratory therapist will verify settings on the machine prior to use. The facility will follow manufacturer instructions for the frequency of cleaning/replacing filters and servicing the machine. Only the supplier may service the machine. The use	F 0695		

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F 0695 SS=D	Continued from page 119 of machine, resident's tolerance, any skin, respiratory or other changes and responses will be documented. Equipment will be replaced immediately when it is broken or malfunctions, or if visible soiling remains after cleaning. Equipment is replaced routinely in accordance with manufacturer recommendations. General guidelines include face mask and tubing once every three months. Head gear, non-disposable filters, and humidifier chamber, once every six months, and disposable filters, twice monthly. Review of the facility policy "Provision of Physician Ordered Services" dated 12/3/24, indicated the purpose of this policy is to provide a reliable process for the proper and consistent provision of physician ordered services according to professional standards of practice. Documentation of consultations, and date/time of physician notification will be maintained in the resident's clinical record. In instances where diagnostic testing or consultations are not available to be performed on-site or the physician has requested that the services be	F 0695		

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F 0695 SS=D	Continued from page 120 performed at an off-site facility, the facility will work with the resident and their family to secure appropriate transportation arrangements for such appointments. Review of the facility policy "Comprehensive Care Plans" dated 12/3/24, indicated it is the policy of the facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment. The comprehensive care plan will be developed within seven days after the completion of the MDS (periodic assessment of care needs). The comprehensive care plan will include measurable objectives and timeframes to meet the resident needs as identified in the resident's comprehensive assessment. The objectives will be utilized to monitor the resident's progress. Alternative interventions will be documented, as needed.	F 0695		

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F 0695 SS=D	Continued from page 121 Review of the clinical record indicated that Resident R17 was admitted to the facility on 7/25/24, with diagnoses of Chronic Obstructive Pulmonary Disease (an ongoing lung condition caused by damage to the lungs), Obstructive Sleep Apnea (a sleep disorder in which the throat muscles relax and block the airway, causing breathing to become restricted and briefly stop), and respiratory failure. Review of Resident R17's clinical record indicated referral paperwork from the hospital effective 7/25/24, uploaded 12/17/24, indicated the resident wears a BIPAP machine at night but states his broke and he hasn't worn it in about 3 nights. Review of Resident R17's Hospital Discharge Summary dated 7/25/24, indicated the resident has COPD and uses 4L (liters) oxygen via nasal canula (medical device that delivers oxygen to your nose through a flexible tube with two prongs) continuously, and has obstructive sleep apnea and uses BIPAP.	F 0695		

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F 0695 SS=D	Continued from page 122 Review of Resident R17's physician orders dated 7/25/24, indicated to follow up with pulmonary within seven days. Review of Resident R17's clinical record from 7/25/24, through 8/1/24, failed to indicate the resident followed up with pulmonary. Review of Resident R17's progress note dated 7/26/24, entered by, Registered Nurse, Employee E9 stated the resident is on oxygen or BIPAP at all times. No physician order was entered for the resident oxygen or BIPAP use. Review of Resident R17's progress note dated 7/28/24, entered by Licensed Practical Nurse, Employee E10 stated "Resident said to writer that he can't breathe." The resident's Spo2 (blood oxygen level that measures how much oxygen is circulating in your bloodstream) was 88% via 2 L nasal cannula. "Care is ongoing."	F 0695		

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F 0695 SS=D	Continued from page 123 Review of Resident R17's active physician order dated 7/28/24, indicated to administer 2L oxygen continuously, every shift for oxygen therapy. Review of Resident R17's MDS dated 8/1/24, indicated the diagnoses were current. Review of Resident R17's "History and Physical" note dated 8/7/24, entered by Medical Doctor, Employee E11 indicated the resident had a history of COPD with respiratory failure and obstructive sleep apnea. It was indicated the resident was on BIPAP with settings of 12/8. The plan was to continue to use his BIPAP. No physician order was entered for the resident's BIPAP settings. Review of Resident R17's clinical record indicated he was transferred out to the hospital on the following dates for respiratory distress. -9/9/24 -9/15/24 -9/18/24 -9/28/24	F 0695		

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F 0695 SS=D	Continued from page 124 -10/30/24 Review of Resident R17's "Readmission" note dated 9/23/24, entered by Nurse Practitioner, Employee E7 indicated the resident was readmitted from the hospital. It was indicated per ER documentation they suspect that him being off the BIPAP at night while in the facility for two nights may have caused him to retain carbon dioxide (a colorless, odorless gas formed by the chemical reaction of carbon and oxygen, and it plays a critical role in various biological and physical processes). The BIPAP settings were adjusted while he was in the hospital. It was indicated he is to use a BIPAP at bedtime. A physician order for BIPAP settings was not entered. Review of Resident R17's physician order dated 10/7/24, entered by Nurse Practitioner, Employee E7 indicated the resident is to wear BIPAP at night and any time during the day when sleeping. The settings were 12/8 with 4L oxygen. Review of Resident R17's hospital discharge	F 0695		

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F 0695 SS=D	Continued from page 125 summary dated 10/31/24, indicated to follow-up with pulmonary within 4-6 weeks. During an interview on 12/16/24, 10:38 a.m. Resident R17's was observed wearing 5 L of oxygen via nasal cannula. Resident R17's BIPAP mask was observed on a dresser next to his bed not in a bag. The mask was unclean and visibly dirty. Resident R17 stated he was unsure the last time it was cleaned. During an interview on 12/16/24, at 10:47 a.m. LPN, Employee E15 confirmed Resident R17 was not receiving his oxygen as ordered, the humidification bottle was undated, and the BIPAP face mask was visibly dirty and not stored properly. During an interview on 12/17/24, at 11:13 a.m. Nurse Partitioner, Employee E7 confirmed Resident R17 did not have an order for BIPAP entered prior to 10/7/24. NP, Employee E7 stated there were orders in the hospital discharge paperwork that did not get put in.	F 0695		

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F 0695 SS=D	Continued from page 126 During an interview on 12/17/24, at 11:36 a.m. Ward Clark, Employee E5 confirmed she is responsible for scheduling appointments. Ward Clark, Employee E5 confirmed Resident R17 has not been scheduled a pulmonary appointment as ordered. During an interview on 12/17/24, at 1:24 p.m. Resident R17's family member expressed concerns regarding Resident R17 hospitalizations and care. During a phone interview on 12/19/24, at 9:06 a.m. Resident R17's Case Manager stated Resident R17's had his BIPAP since he has been at the facility. It was indicated the facility can't take care of him, that's why he keeps going back to the hospital. During an observation and interview on 12/19/24, at 9:57 a.m. Resident R17's BiPAP mask was observed not in a bag again. Resident R17 stated "I told them to put it in the bag." Resident R17's BIPAP filter was observed filthy with lint. Resident	F 0695		

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F 0695 SS=D	Continued from page 127 R17 stated he has never refused his BIPAP, and stated "I know I need it. I don't mind it." During an interview on 12/19/24, at 10:10 a.m. RN, Employee E16 confirmed Resident R17's BIPAP mask was not stored properly and the BIPAP filter was unclean. During an interview on 12/19/24, at 1:30 p.m. the Nursing Home Administrator confirmed Resident R17 had a BIPAP since he was admitted on 7/25/24, with no orders for settings or to clean the machine. It was indicated on 9/16/24, the facility rented a new BIPAP machine because Resident R17's was not working. The NHA confirmed the facility failed to provide appropriate respiratory care for one of three residents (Residents R17). 28 Pa. Code: 201.14(a) Responsibility of licensee 28 Pa. Code 211.12(d)(1)(2)(5) Nursing services	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 0698 SS=D	483.25(l) Dialysis §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by:	F 0698	R64 suffered no adverse effects due to communication binder not being completely filled out. Communication book updated retroactively to reflect missing dates. Education was immediately provided to nursing staff and will be completed on the importance of utilizing the communication binder by DON or designee on or before 2/11/2025. Audits will be completed by DON or designee on communication binder to ensure consistent dialysis communication 3 x weekly for 4 weeks and monthly x 1 month. Audit results will be reviewed through the monthly QAPI process/meeting.	Completion Date: **02/11/2025** Status: **APPROVED** Date: **01/28/2025**

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F 0698 SS=D	Continued from page 129 Based on review of facility policy and clinical record and staff interview it was determined that the facility failed to make certain consistent dialysis communication was maintained for one of one dialysis resident (Resident R64). Findings include: Review of the admission record indicated Resident R64 was admitted to the facility on 8/5/21. Review of Resident R64's Minimum Data Set (MDS - a periodic assessment of care needs) dated 10/29/24, indicated the diagnoses of heart failure (heart doesn't pump blood as well as it should), renal failure (condition where the kidneys lose the ability to remove waste and balance fluids) with dialysis, and high blood pressure. Review of current physician orders on 1/30/24, indicated Resident R64 attends dialysis on Monday, Wednesday, and Friday each week.	F 0698		

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F 0698 SS=D	Continued from page 130 A review of the clinical record did not include complete communication forms for the month of December 2024. There were seven incomplete communication sheets (Portion Completed by Nursing Home was incomplete) for the following dates: 12/6/24, 12/9/24, 12/11/24, 12/13/24, 12/16/24 and two without a date. Interview on 12/17/24, at 10:59 a.m. Licensed Practical Nurse confirmed the above dates did not include complete communication forms as required for Resident R64. Interview on 12/17/24, at 2:55 p.m. the Nursing Home Administrator confirmed the facility failed to make certain consistent dialysis communication was maintained for one of one dialysis resident (Resident R39). 28 Pa. Code: 201.14(a) Responsibility of licensee. 28 Pa. Code: 211.10(d) Resident care policies. 28 Pa. Code: 201.18 (b) (1) (e) (1) Management. 28 Pa. Code: 211.12 (d) (1) (2) (5) Nursing	F 0698		

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F 0698 SS=D	Continued from page 131 services.	F 0698		
F 0699 SS=D	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	R36 and R85 care plans were immediately updated to include PTSD. Like residents were audited to ensure no other care plans needed modifications for PTSD. Request submitted to PCC on 1/8/2025 to add PTSD form. Education on PTSD will be provided to the social workers and RNAC by the NHA or designee on or before 2/11/2025. Audits will be conducted on PTSD on care plans by DON or designee weekly x 4 weeks and monthly x 1 month. Audit results will be reviewed through the monthly QAPI process/meeting.	Completion Date: **02/11/2025** Status: **APPROVED** Date: **01/28/2025**

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F 0699 SS=D	Continued from page 132 Based on review of facility policy, resident record review, and staff interviews, it was determined that the facility failed to provide a trauma survivor with trauma informed care to eliminate or mitigate triggers that may cause re-traumatization of the resident for two of two residents (Resident R36 and R85). Findings include: Review of facility policy "Trauma Informed Care" dated 12/3/24, indicated the facility will collaborate with resident trauma survivors, and as appropriate, the resident's family, friends, the primary care physician, and any other health professionals to develop and implement individualized care plan interventions. The facility will identify triggers which may re-traumatize residents with a history of trauma. Trigger-specific interventions will identify ways to decrease the resident's exposure to triggers which may re-traumatize the resident, as well as identify ways to mitigate or decrease the effect of the trigger on the resident, and will be added to the residents care plan.	F 0699		

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F 0699 SS=D	Continued from page 133 Review of the clinical record indicated Resident R36 was admitted to the facility on 10/25/24. Review of Resident R36's Minimum Data Set (MDS - a periodic assessment of care needs) dated 11/1/24, indicated diagnoses of high blood pressure, muscle wasting, and Post Traumatic Stress Disorder (PTSD - a disorder in which a person has difficulty recovering after experiencing or witnessing a terrifying event and may have triggers that can bring back memories of trauma accompanied by intense emotional and physical reactions). Review of Resident R36's care plan on 12/16/24, did not include a plan of care developed with goals and interventions related to post-traumatic stress disorder. During an interview on 12/17/24, at 10:04 a.m. Registered Nurse Assessment Coordinator (RNAC) Employee E2 confirmed that the facility failed to develop a care plan related to	F 0699		

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F 0699 SS=D	Continued from page 134 post-traumatic stress disorder for Resident R36. Review of the clinical record indicated Resident R85 was admitted to the facility on 11/19/24. Review of Resident R85's MDS dated 11/26/24, indicated diagnoses of anxiety, depression, and PTSD. Review of Resident R85's care plan on 12/16/24, did not include a plan of care developed with goals and interventions related to post-traumatic stress disorder. During an interview on 12/17/24, at 11:03 a.m. Resident R85 stated no one from the facility has asked her about her trauma or triggers. During an interview on 12/17/24, at 1:00 p.m. Social Services Director Employee E4 confirmed that the facility failed to provide a trauma survivor with trauma informed care to eliminate or mitigate triggers that may cause re-traumatization of the	F 0699		

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F 0699 SS=D	Continued from page 135 resident for two of two residents (Resident R36 and R85). 28 Pa. Code: 201.14(a) Responsibility of licensee. 28 Pa. Code: 201.18(b)(1) Management.	F 0699		
F 0700 SS=D	483.25(n)(1)-(4) Bedrails §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails.	F 0700	Side Rail/Grab Bar Review was completed on R56 retroactively. Like residents were assessed to ensure appropriate side rail/grab bar placement. Like residents assessed to ensure up to date assessments are completed Education will be provided to the RNAC, Nurses and nursing management on side rail/grab bar review on or before 2/11/2025. Audits will be completed by the DON or designee weekly to ensure up to date assessments are completed x 4 weeks and monthly x 1 month. Audit results will be reviewed through the monthly QAPI process/meeting.	Completion Date: **02/11/2025** Status: **APPROVED** Date: **01/28/2025**

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F 0700 SS=D	Continued from page 136 This REQUIREMENT is not met as evidenced by:	F 0700		

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F 0700 SS=D	Continued from page 137 Based on observations, review of facility policy, clinical record review, and staff interview, it was determined that the facility failed to conduct ongoing accurate assessments to ensure that bedrails were used to meet residents' needs and the risks associated with bedrail usage for one of two residents (Resident R56). Findings include: Review of facility policy "Proper Use of Bed Rails" dated 12/3/24, indicated a nurse assigned to the resident will complete reassessments in accordance with the facility's assessment schedule, but not less than quarterly, upon a significant change in status, or a change in the type of bed/mattress/rail. Review of the clinical record indicated Resident R56 was admitted to the facility on 2/23/21. Review of Resident R56's Minimum Data Set (MDS - a periodic assessment of care needs) dated 11/2/24, indicated diagnoses of high blood pressure,	F 0700		

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F 0700 SS=D	Continued from page 138 muscle weakness, and anemia (too little iron in the blood). Review of a physician order dated 7/26/22, indicated bilateral (both sides) bed enablers (enabler bars) to promote bed mobility independence. Review of Resident R56's care plan dated 3/19/21, indicated I require the use of bilateral enablers when in bed to assist with bed mobility, positioning, transfers in and out of bed and to increase functional independence. A nursing assessment will be completed quarterly, annually and with significant change in my status for the need of enablers. Review of Resident R56's clinical record revealed the last "Side Rail/Grab Bar Review" was completed on 5/2/24. During an observation on 12/16/24, at 11:24 a.m. two top enabler bars were present on Resident R56's bed.	F 0700		

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F 0700 SS=D	Continued from page 139 During an interview on 12/20/24, at 12:49 p.m. the Director of Nursing (DON) confirmed that the "Side Rail/Grab Bar Review" was last completed for Resident R56 on 5/2/24. During an interview on 12/20/24, at 12:49 p.m. the DON confirmed that the facility failed to conduct ongoing accurate assessments to ensure that bedrails were used to meet residents' needs and the risks associated with bedrail usage for one of two residents (Resident R56). 28 Pa. Code: 201.14 (a) Responsibility of licensee. 28 Pa. Code: 211.12 (d) (1)(3)(5) Nursing services. 28 Pa. Code 211.10(c)(d) Resident care policies.	F 0700		
F 0711 SS=D		F 0711		

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F 0711 SS=D	Continued from page 140 483.30(b)(1)-(3) Physician Visits - Review Care/Notes/Order §483.30(b) Physician Visits The physician must- §483.30(b)(1) Review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section; §483.30(b)(2) Write, sign, and date progress notes at each visit; and §483.30(b)(3) Sign and date all orders with the exception of influenza and pneumococcal vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications. This REQUIREMENT is not met as evidenced by:	F 0711	Meeting immediately held with Medical Director with NHA, Interim ADON, and UM to discuss reviewing medications and treatments. Chart review conducted on R17 to ensure no adverse effects. Like residents reviewed to ensure medications and treatments being accurately followed by physicians. Education will be provided to nurses on medications and treatments being accurately followed on or before 2/11/2025. Education will be provided to the RNAC, Nurses and nursing management on BIPAP management on or before 2/11/2025. Audits will be completed on BIPAP to ensure proper use by the DON or designee weekly x 4 weeks and monthly x 1 month. Audit results will be reviewed through the monthly QAPI process/meeting.	Completion Date: **02/11/2025** Status: **APPROVED** Date: **01/28/2025**

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F 0711 SS=D	Continued from page 141 Based on review of clinical records, hospital records review, facility policy review, and staff interview, it was determined that the facility failed to ensure that the resident's total program of care, including medications and treatments, were reviewed with accuracy at each physician visit for one of three residents reviewed (Resident 1). Findings include: Review of the facility policy "Provision of Physician Ordered Services" dated 12/3/24, indicated the purpose of this policy is to provide a reliable process for the proper and consistent provision of physician ordered services according to professional standards of practice. Review of the clinical record indicated that Resident R17 was admitted to the facility on 7/25/24, with diagnoses of Chronic Obstructive Pulmonary Disease (an ongoing lung condition caused by damage to the lungs), Obstructive Sleep Apnea (a sleep disorder in which the throat muscles relax and	F 0711		

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F 0711 SS=D	Continued from page 142 block the airway, causing breathing to become restricted and briefly stop), and respiratory failure. Review of Resident R17's MDS dated 8/1/24, indicated the diagnoses were current. Review of Resident R17's "History and Physical" note dated 8/7/24, entered by Doctor of Medicine, Employee E11 indicated the resident had a history of COPD with respiratory failure and obstructive sleep apnea. It was indicated the resident was on BIPAP with settings of 12/8. The plan was to continue to use his BIPAP. No physician order was entered for the resident's BIPAP settings. Review of Resident R17's "Readmission" note dated 9/23/24, entered by Nurse Practitioner, Employee E7 indicated the resident was readmitted from the hospital. It was indicated per ER documentation they suspect that him being off the BIPAP at night while in the facility for two nights may have caused him to retain CO2. The BIPAP settings were adjusted while he was in the hospital. It was	F 0711		

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F 0711 SS=D	Continued from page 143 indicated he is to use a BIPAP at bedtime. A physician order for BIPAP settings was not entered. Review of Resident R17's physician order dated 10/7/24, entered by Nurse Practitioner, Employee E7 indicated the resident is to wear BIPAP at night and any time during the day when sleeping. The settings were 12/8 with 4L oxygen. During an interview on 12/17/24, at 11:13 a.m. Nurse Partitioner, Employee E7 confirmed Resident R17 did not have an order for BIPAP entered prior to 10/7/24. Nurse Practitioner, Employee E7 stated there were orders in the hospital discharge paperwork that did not get put in. During an interview on 12/19/24, at 10:25 a.m. Doctor of Medicine, Employee E11 confirmed the facility failed to ensure that the resident's total program of care, including medications and treatments, were reviewed with accuracy at each physician visit for one of three residents reviewed (Resident 17).	F 0711		

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F 0711 SS=D	Continued from page 144 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18(b)(1)(3) Management 28 Pa. Code 211.5(ii)(iv)(vii) Medical records	F 0711		
F 0730 SS=D	483.35(d)(7) Nurse Aide Peform Review-12 hr/yr In-Service §483.35(d)(7) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g). This REQUIREMENT is not met as evidenced by:	F 0730	Performance evaluation completed retroactively on employee E26. A review of current nurses aides were completed to ensure no other annual evals were missed. Education on evaluations will be provided to HR by the NHA or designee on or before 2/11/2025. Audits will be conducted on evaluations to ensure they are completed timely by DON or designee weekly x 4 weeks and monthly x 1 month. Audit results will be reviewed through the monthly QAPI process/meeting.	Completion Date: **02/11/2025** Status: **APPROVED** Date: **01/28/2025**

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F 0730 SS=D	Continued from page 145 Based on review of facility policy, personnel records and staff interview it was determined that the facility failed to complete annual performance evaluations for one of three nurse aide personnel records (Nurse Aide Employee E26). Findings include: The facility "Certified Nursing Assistant" position description last reviewed 12/3/24, indicated that compliance is a factor in evaluating job performance. It was indicated individual performance will be evaluated using a scale ranging from unsatisfactory to exceeds standards. Review of Nurse aide (NA) Employee E26's personnel record indicated she was hired to the facility on 11/30/23. The record indicated that the position description and the employee handbook were both signed on 11/30/23. Review of Nurse aide (NA) Employee E26's performance evaluation on 12/20/24, at 9:30 a.m.	F 0730		

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F 0730 SS=D	Continued from page 146 for the evaluation period of 11/30/23 to 1/30/24, failed to reveal an annual performance evaluation was performed. During an interview on 12/20/24, at 9:38 p.m. the Director of Human Resources Employee E22 confirmed that the facility failed to complete an annual performance evaluation for NA Employee E26 as required. 28 Pa Code: 201.20 (a)(b)(c)(d) Staff development.	F 0730		
F 0755 SS=D		F 0755		

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F 0755 SS=D	Continued from page 147 483.45(a)(b)(1)-(3) Pharmacy Srvcs/Procedures/Pharmacist/Records §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.	F 0755	R55 suffered no ill effects by not having medications disposed of timely. Education on destroying medications will be provided to Nurses by the DON or designee on or before 2/11/2025. Audit of med rooms and carts completed to ensure no other discontinued meds were present. Audits will be conducted on destroyed medications and reconciling of medications weekly x 4 weeks and monthly x 1 month. Audit results will be reviewed through the monthly QAPI process/meeting.	Completion Date: **02/11/2025** Status: **APPROVED** Date: **01/28/2025**

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F 0755 SS=D	Continued from page 148 This REQUIREMENT is not met as evidenced by:	F 0755		

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F 0755 SS=D	Continued from page 149 Based on review of facility policy, review of clinical documentation. observation and staff interview it was determined the facility failed to dispose and reconcile discontinued medication in a timely manner for one of two residents (Resident R55). Findings: Review of facility policy " Discontinued Medications", dated 12/3/24, indicated when medications are discontinued by prescriber order, a resident is transferred or discharged and does not take medications with him or her, or in the event of resident ' s death, the medications are marked as discontinued and destroyed or returned to the issuing pharmacy. Medications are stored in a locked secure area designated for that purpose until destroyed. Review of the clinical record indicated Resident R55 was admitted to the facility on 8/9/24. Review of Resident R55's Minimum Data Set	F 0755		

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F 0755 SS=D	Continued from page 150 (MDS - a periodic assessment of care needs) dated 11/16/24, indicated diagnoses of depression, muscle weakness, and hypothyroidism (a condition in which they thyroid gland doesn't produce enough thyroid hormone. Review of Resident R55's physician orders dated 12/17/24, indicated that Buspirone (a medication used to treat anxiety) 7.5 mg was ordered with a discontinued date of 12/17/24. During an observation on 12/20/24, at 12:07 p.m. the facility had a blister pack of Buspirone 7.5 mg laying on a shelf beside the refrigerator in the medication room. The blister pack of Buspirone contained 28 pills. During an interview on 12/20/24 at 12:15 p.m. Registered Nurse Employee E14 stated, "The facility should have destroyed them when the order was discontinued". During an interview on 12/20/24, at 2:23 p.m. the	F 0755		

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F 0755 SS=D	Continued from page 151 Director of Nursing confirmed that the facility failed to dispose and reconcile discontinued medication in a timely manner for one of two residents (Resident R55). 28 Pa. Code211.12(d)(1)(3)(5) Nursing services.	F 0755		
F 0756 SS=D		F 0756		

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F 0756 SS=D	Continued from page 152 483.45(c)(1)(2)(4)(5) Drug Regimen Review, Report Irregular, Act On §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record.	F 0756	R48 and R53 suffered no ill effects in regard to medication pharmacy review. MD reviewed and completed Medication Regimen Reviews for R48 and R53. House audit conducted to make sure no other MMR's were missing. Meeting held with pharmacy with Interim DON, NHA and Unit Manager to discuss process on clinical and medication pharmacy review, re-training provided to NHA, ADON, and Unit Manager on 1/9/2025 by Pharmerica and additional pharmacy system access provided. Audits will be conducted on following medication regimen reviews weekly and ensuring MMRs are addressed and in record x 4 weeks and monthly x 1 month. Audit results will be reviewed through the monthly QAPI process/meeting.	Completion Date: **02/11/2025** Status: **APPROVED** Date: **01/28/2025**

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F 0756 SS=D	Continued from page 153 §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by:	F 0756		

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F 0756 SS=D	Continued from page 154 Based on clinical record review, facility policy review, and staff interviews, it was determined that the facility failed to ensure Medication Regimen Reviews (MRR) were completed by the facility after the consultant pharmacist recommendations were made for two of two residents (Resident R48, and Resident R53). Findings include: The facility policy "Medication Regimen Review and Reporting" reviewed 12/3/24, indicated a MRR is a thorough evaluation of the medication regimen of a resident, with the goal of promoting positive outcomes and minimizing adverse consequences and potential risks associated with medication. The consultant pharmacist reviews the medication regimen and medical chart of each resident at least monthly to appropriately monitor the medication regimen and ensure that the medications each resident receives are clinically indicated. Review of Resident R48's admission record	F 0756		

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F 0756 SS=D	Continued from page 155 indicated she was admitted to the facility on 7/31/23. Review of Resident R48's MDS assessment (Minimum Data Set assessment: MDS -a periodic assessment of resident care needs) dated 11/26/24, indicated the diagnoses high blood pressure, depression, and dementia (a group of symptoms that affects memory, thinking and interferes with daily life). Review of Resident R48's clinical pharmacy review notes on 12/20/24, at 10:00 a.m. indicated the following: January 2024 - no recommendations in clinical record March 2024- no recommendations in clinical record May 2024- no recommendations in clinical record July 2024- no recommendations in clinical record September 2024- no recommendations in clinical record December 2024 - no recommendations in clinical	F 0756		

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F 0756 SS=D	Continued from page 156 record Review of Resident R53's clinical record indicated the resident was admitted to the facility on 12/24/19. Review of Resident R53's MDS dated 10/11/24, indicated diagnoses of high blood pressure, diabetes (a metabolic disorder in which the body has high sugar levels for prolonged periods of time), and dementia (a group of symptoms that affects memory, thinking and interferes with daily life). Review of Resident R53's clinical pharmacy review notes on 12/20/24, at 10:00 a.m. indicated the following: January 2024 - no recommendations in clinical record March 2024 - no recommendations in clinical record April 2024 - no recommendations in clinical record July 2024 - no recommendations in clinical record	F 0756		

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F 0756 SS=D	Continued from page 157 September 2024 - no recommendations in clinical record December 2024 - no recommendations in clinical record During an interview on 12/20/24, at 11:30 a.m. the Director of Nursing (DON) stated, "I know the pharmacy does monthly reviews, but I can't find them in the residents record". During an interview on 12/20/24, at 12:52 p.m. the DON confirmed that the facility failed to ensure Medication Regimen Reviews (MRR) were completed by the facility after the consultant pharmacist recommendations were made for two out of two residents (Resident R48, and Resident R53). 28 Pa Code: 201.14 (a) Responsibility of licensee. 28 Pa. Code 211.5(f) Clinical records. 28 Pa. Code 211.9 (k) Pharmacy services.	F 0756		

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F 0761 SS=E	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	Medication cart on 3A was immediately locked. Liquid medication on 3A was removed. Lock box on 2BC was locked and replaced. Education on locking carts, the process of passing medications and locking narcotic boxes will be provided to nurses by the DON or designee on or before 2/11/2025. Audits will be conducted on locking carts, the process of passing medications and locking narcotic boxes weekly on 2 nurses/med passes x 4 weeks and monthly x 1 month. Audit results will be reviewed through the monthly QAPI process/meeting.	Completion Date: **02/11/2025** Status: **APPROVED** Date: **01/28/2025**

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F 0761 SS=E	Continued from page 159 Based on review of facility policy, observations, and staff interviews, it was determined that the facility failed to properly store medical supplies and biologicals in one of three medication carts (3A medication cart), and in one of three medication rooms (Medication room 2BC) and failed to properly secure a medication cart for one of three medication carts (3A medication cart). Findings include: Review of facility "Medication Storage" policy dated 12/3/24, indicated the facility will ensure all medication housed on our premises will be stored in the medication rooms according to manufacturer's guideline. All drugs and biologicals will be stored in locked compartments. During a medication pass, medication must be under the direct observation of the person administering medications or locked in the medication storage area or cart. During a tour of the facility on 12/17/24, at 10:53 a.m. revealed a medication cart that was	F 0761		

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ARMSTRONG REHABILITATION AND NURSING CENTER STATE LICENSE NUMBER: **530602**	**265 S MCKEAN STREET KITTANNING, PA 16201**

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F 0761 SS=E	Continued from page 160 unattended, and unlocked on 3A. During an interview on 12/17/24, at 11:00 a.m. Licensed Practical Nurse (LPN) Employee E23 confirmed that 3A medication cart was unlocked. During an observation on a medication pass on 12/18/24, at 9:50 a.m. revealed a liquid medication in a cup poured sitting on top of the medication cart 3A. During an interview on 12/18/24, at 9:53 LPN Employee E24 stated "I'm waiting for a resident to finish eating then I am going to give it to her". During an interview on 12/18/24, at 9:55 a.m. LPN Employee E24 confirmed that a pre-poured medication was sitting on top of the medication cart and was not given to the resident. During a medication room storage review on 12/20/24, at 11:50 a.m. revealed that the secured narcotic lock box inside the refrigerator was	F 0761		

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F 0761 SS=E	Continued from page 161 unlocked with two oral concentrated Ativan (narcotic controlled medication used to treat anxiety) in it. During an interview on 12/20/24, at 12:05 p.m. LPN Employee E25 confirmed that the narcotic lock box was unlocked in medication room 2BC. 28 Pa. Code: 211.9(a)(1)(k) Pharmacy services. 28 Pa. Code: 211.10(c) Resident care policies. 28 Pa. Code 211.12(d)(1)(5) Nursing services.	F 0761		
F 0773 SS=D		F 0773		

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F 0773 SS=D	Continued from page 162 483.50(a)(2)(i)(ii) Lab Srvcs Physician Order/Notify of Results §483.50(a)(2) The facility must- (i) Provide or obtain laboratory services only when ordered by a physician; physician assistant; nurse practitioner or clinical nurse specialist in accordance with State law, including scope of practice laws. (ii) Promptly notify the ordering physician, physician assistant, nurse practitioner, or clinical nurse specialist of laboratory results that fall outside of clinical reference ranges in accordance with facility policies and procedures for notification of a practitioner or per the ordering physician's orders. This REQUIREMENT is not met as evidenced by:	F 0773	Physician was notified about R34's abnormal laboratory test results. A lookback of 30 days will be conducted to ensure physicians were notified of any abnormal laboratory test results. Licensed nurses will be educated by DON or designee to notify physician of any abnormal laboratory tests in a timely manner, and to verify the date on the results. Audits will be conducted by DON or designee weekly to ensure abnormal lab results are communicated to the physician x4 weeks then monthly x1 months to ensure physicians are notified of abnormal lab results. Results of audits will be reviewed through the QAPI process/meeting.	Completion Date: **02/11/2025** Status: **APPROVED** Date: **01/28/2025**

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F 0773 SS=D	Continued from page 163 Based on review of facility policy, review of clinical records, and staff interview it was determined that the facility failed to ensure that a resident's physician was promptly notified about abnormal laboratory test results for one of two residents (Resident R34) Findings include: The facility policy "Notification of Changes: dated 12/3/24, and previously dated 9/12/24, indicated that the facility will promptly inform the physician when there is a change requiring notification. Review of the clinical record revealed that Resident R34 was admitted to the facility on 9/9/24 from a hospital. Review of Resident 34's MDS dated 9/16/24, indicated diagnoses of high blood pressure, diabetes (a disorder in which the body has high sugar levels for prolonged periods of time), and pain. Review of medical records revealed that Resident	F 0773		

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F 0773 SS=D	Continued from page 164 R34 had a physician's order dated 9/20/24, indicated to complete a CBC (Complete Blood Count- a group of blood tests that measure the number and size of the different cells in your body), and BMP (Basal Metabolic Panel- a blood test that measures the body's metabolism). Review of Resident R34's lab results dated 9/20/24, indicated the following out of range results: BUN 28 RBC 3.28 HGB 9.0 HCT 29.7 MCHC 30.3 Review of Resident R34's clinical record did not include a call to the physician to review the abnormal results and/or obtain new orders related to the results from 9/20/24. Review of medical records revealed that Resident R34 had a physician's order dated 12/4/24, indicated to complete a CBC, and BMP.	F 0773		

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F 0773 SS=D	Continued from page 165 Review of Resident R34's lab results dated 12/4/24, indicated the following out of range results: Glucose 111 BUN 40 Creatinine 1.5 Anion Gap 2 Review of Resident R34's clinical record did not include a call to the physician to review the abnormal results and/or obtain new orders related to the results from 12/4/24. Review of medical records revealed that Resident R34 had a physician's order dated 12/9/24, indicated to complete a BMP, and an H and H level (a blood test that provides information about the oxygen-carrying capacity of the blood). Review of Resident R34's lab results dated 12/4/24, indicated the following out of range results: BUN 37 Anion Gap 1	F 0773		

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F 0773 SS=D	Continued from page 166 HGB 8.5 HCT 26.6 Review of Resident R34's clinical record revealed a signature from a nurse practitioner that labs from 12/9/24, were reviewed, however it failed to indicate a date that this was reviewed to ensure a prompt notification. During an interview on 12/20/24, at 12:18 p.m. the Director of Nursing (DON) confirmed that the facility failed to ensure that a resident's physician was notified promptly about abnormal laboratory test results for Resident R34. 28 Pa. Code 211.12(d)(3)(5) Nursing services.	F 0773		
F 0791 SS=D		F 0791		

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F 0791 SS=D	Continued from page 167 483.55(b)(1)-(5) Routine/Emergency Dental Srvcs in NFs §483.55 Dental Services The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(b) Nursing Facilities. The facility- §483.55(b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(f) of this part, the following dental services to meet the needs of each resident: (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services; §483.55(b)(2) Must, if necessary or if requested, assist the resident- (i) In making appointments; and (ii) By arranging for transportation to and from the dental services locations; §483.55(b)(3) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay;	F 0791	R45 was offered but refused dental services (1/8/2025) Other residents with no payor were audited to determine if they had any urgent dental needs. DON or designee will audit dental services needs weekly x4 weeks then monthly x2 months. Audit results will be reviewed through the monthly QAPI process	Completion Date: **02/11/2025** Status: **APPROVED** Date: **01/28/2025**

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F 0791 SS=D	Continued from page 168 §483.55(b)(4) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; and §483.55(b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan. This REQUIREMENT is not met as evidenced by:	F 0791		

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F 0791 SS=D	Continued from page 169 Based on review of facility policies, clinical record review, and staff interviews, it was determined that the facility failed to provide timely dental services for one of two residents reviewed (Resident R45). Findings include: Review of facility policy "Dental Services" dated 12/3/24, indicated the facility is to assist residents in obtaining routine (to the extent covered under the State plan) and emergency dental care. Emergency dental services includes services needed to treat and episode of acute pain in teeth, gums, or palate; broken, or otherwise damaged teeth, or any other problem of the oral cavity that required immediate attention by a dentist. Review of the clinical record indicated Resident R45 was admitted to the facility on 10/2/24. Review of Resident R45's Minimum Data Set (MDS - a periodic assessment of care needs) dated 11/26/24, indicated diagnoses of high blood	F 0791		

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F 0791 SS=D	Continued from page 170 pressure, muscle weakness, and adult failure to thrive (seen in older adults with multiple medical conditions resulting in downward spiral of poor nutrition, weight loss, inactivity, depression, and decrease in functional abilities). Review of a physician order dated 11/26/24, indicated dental consult ASAP (as soon as possible), for abscess (a swollen area within body tissue, containing an accumulation of pus)/infection. Review of Resident R45's care plan dated 11/27/24, indicated the resident is on antibiotic therapy related to dental abscess. Review of a progress note dated 11/26/24, at 8:14 a.m. completed by Licensed Practical Nurse (LPN) Employee E20 stated, "During morning medication pass, noted philtrum area (space between nose and upper lip) to be swelled and tender to touch. Client opened mouth and noted a sore on the top left side of mouth. Client is able to chew food/eat/drink. Educated client if she I having difficulty	F 0791		

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F 0791 SS=D	Continued from page 171 eating/chewing to let staff know so diet can be changed accordingly. Alerted Nurse Practitioners/physician and provided ice for area." Review of a physician order dated 11/26/24, indicated to administer Clindamycin Phosphate 600 mg (milligrams) intravenously (through a vein) every 8 hours for dental infection for 7 days. Review of a progress note dated 11/29/24, completed by Certified Registered Nurse Practitioner (CRNP) Employee E6 stated, "Resident R45 seen today for follow up of dental infection, pain, and elevated blood sugar. Patient seen while resting in bed in NAD (no acute distress). Swelling to top lip much improved, no longer red or swollen. Patient reports pain is gone and she is feeling much better. IV (intravenous) antibiotics changed to PO (by mouth) for remainder of treatment. Assessment and plan for dental abscess/infection, discontinue IV start PO Clindamycin 300 mg QID (four times a day) x 5 days. Start Peridex (a germicidal mouthwash that reduces bacteria in the mouth)	F 0791		

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F 0791 SS=D	Continued from page 172 swish and spit mouth rinse BID (twice a day), dental consult, monitor worsening condition." Review of a progress note dated 12/2/24, completed by CRNP Employee E6 stated, "Resident R45 seen today for follow up of dental infection/abscess. Patient seen while resting in bed in NAD. She reports feeling much better. Denies any pain to upper lip/gum area. Swelling resolved. No difficulty eating or drinking at present. Upper gum area with small red, swollen area under lip, so symptoms of infection at present. Teeth remain decayed/chipped. Awaiting dental appointment." Review of a progress note dated 12/4/24, completed by CRNP Employee E6 stated, "Resident R45 seen today for follow up of dental abscess and diabetes. Patient seen while resting in bed in NAD. Swelling to upper lip resolved since antibiotics, now completed. Denies any further pain/discomfort. Assessment and plan for dental abscess/infection, completed Clindamycin with improvement in symptoms. Continue Peridex swish	F 0791		

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F 0791 SS=D	Continued from page 173 and spit mouth rinse BID. Dental consult pending for decayed teeth." Review of a physician order dated 12/18/24, indicated to administer Augmentin 875 mg-125 mg give one tablet by mouth every 12 hours for dental infection for 7 days. Review of a progress note dated 12/18/24, completed by CRNP Employee E7 stated, "Resident R45 seen today while resting in bed in NAD. Lab and abdominal x-ray results. Labs indicated critical blood glucose at 465 and WBC (white blood count) elevated at 12.8. Was recently treated for dental infection with current elevated WBC of 12.8. Assessment and plan for leukocytosis (elevated WBC level) possible returning dental infection, start Augmentin 875 mg-125 mg BID for 7 days until 12/25." Review of Resident R45's clinical record on 12/19/24, failed to indicate that Resident R45 received dental services as ordered.	F 0791		

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F 0791 SS=D	Continued from page 174 During an interview on 12/19/24, at 12:41 p.m. Ward Clerk Employee E5 stated, "The dentist is coming to the facility on January 8th, I have Resident R45 on the list to be seen. I was unable to get her an appointment anywhere outside of the facility because she was MA (medical assistance) pending at the time the dental consult order was written. She has insurance now. The dentist did come to the facility this month, but I was unable to put her on the list to be seen because she was MA pending." During an interview on 12/19/24, at 1:02 p.m. the Business Office Manager Employee E8 stated, "Resident R45 was just recently approved for medical assistance. She did not have insurance coverage at the time of admission that I can recall." During an interview on 12/20/24, at 1:59 p.m. the Nursing Home Administrator (NHA) stated, "I left a message with our dental provider that comes into the facility. They stated they want payment the day	F 0791		

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F 0791 SS=D	Continued from page 175 of services, but we're going to have to work something out going forward." During this interview, the NHA confirmed that the facility failed to provide timely dental services for one of two residents as required. 28 Pa. Code 211.12(d)(3) Nursing services. 28 Pa. Code 211.15 Dental services.	F 0791		
F 0825 SS=D	483.65(a)(1)(2) Provide/Obtain Specialized Rehab Services §483.65 Specialized rehabilitative services. §483.65(a) Provision of services. If specialized rehabilitative services such as but not limited to physical therapy, speech-language pathology, occupational therapy, respiratory therapy, and rehabilitative services for mental illness and intellectual disability or services of a lesser intensity as set forth at §483.120(c), are required in the resident's comprehensive plan of care, the facility must- §483.65(a)(1) Provide the required services; or §483.65(a)(2) In accordance with §483.70(f), obtain the required services from an outside resource that is a provider of specialized rehabilitative services and is not excluded from participating in any federal or state health care programs pursuant to section 1128 and 1156 of the Act.	F 0825	R87 was picked up retroactively by therapy on 12/19/2024. 30 day lookback of like residents to ensure no other residents were affected. New form created to review residents with possible therapy needs. DON or designee will audit residents for therapy needs weekly for 4 weeks and monthly for 1 month. Audit results will be reviewed through the monthly QAPI process.	Completion Date: **02/11/2025** Status: **APPROVED** Date: **01/28/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395471	A. BLDG: __00_____ B. WING: _____	12/20/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
ARMSTRONG REHABILITATION AND NURSING CENTER STATE LICENSE NUMBER: **530602**	**265 S MCKEAN STREET KITTANNING, PA 16201**

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F 0825 SS=D	Continued from page 176 This REQUIREMENT is not met as evidenced by:	F 0825		

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F 0825 SS=D	Continued from page 177 Based on a review of facility documents, and resident and staff interview, it was determined that the facility failed to provide specialized rehabilitative services for one of six residents (Resident R87). Findings Include: Review of the clinical record revealed that Resident R87 was admitted to the facility on 11/26/24. Review of Resident 87's MDS (Minimum Data Set, periodic assessment of resident care needs) dated 12/3/24, indicated diagnoses of high blood pressure, heart failure (a progressive heart disease that affects pumping action of the heart muscles), and diabetes (a disorder in which the body has high sugar levels for prolonged periods of time). Review of medical records revealed that Resident R87 had physician's orders for Physical Therapy (PT) Evaluation and Treatment as needed, and Occupational Therapy (OT) Evaluation and	F 0825		

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 0825 SS=D	Continued from page 178 Treatment as needed, and a Speech Therapy (ST) Evaluation and Treatment as needed, all dated 11/26/24. Review of medical record revealed a "Rehabilitation Admission Screen" dated 11/26/24, indicated that Resident R87 was screened for PT, OT, and ST, however it was noted that Resident R87 was to be "Screened only per NHA" (Nursing Home Administrator). PT noted that Resident R87 is recommended for PT as she has had a decline in functional mobility as prior to admission she walked community distances without an assisted device, and now requires a front wheeled walker and is with limited distance. OT noted that Resident R87 is recommended for OT to promote activities of daily living and functional mobility and independence with positioning, seating, balance, safety, activity tolerance, general strength and decrease the risk of falls during functional tasks. High risk for falls. Wheelchair seating system recommended at this time.	F 0825		

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F 0825 SS=D	Continued from page 179 During an interview on 12/16/24, at 11:37 a.m. Resident R87 indicated that she had not received any therapy, as the facility was filling out her insurance paperwork. During an interview on 12/17/24, at 2:15 p.m. Rehabilitation Manager (RM) Employee E17 stated that the Resident R87 was not picked up by therapy as she did not have insurance. During an interview on 12/18/24, at 10:17 a.m. Business Officer Manager (BOM) Employee E8 stated that Resident R87 had applied for medical assistance to pay for her stay upon admission, and that this this status was "pending". BOM Employee E8 stated that it appears that she will be approved but confirmed that she has not started the therapy services that she was ordered. During an interview on 12/18/24, at 1:44 p.m. RM Employee E17 stated that Resident R87 was screened only but not started on therapy services until a payer source was obtained.	F 0825		

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F 0825 SS=D	Continued from page 180 During an interview on 12/18/24, at 1:46 p.m. NHA confirmed that the facility failed to administer therapy sources as ordered for Resident R87 and stated, "I just told therapy to screen her". 28 Pa Code: 201.18(e)(1) Management. 28 Pa. Code: 211.10(c)(d) Resident care policies.	F 0825		
F 0842 SS=E		F 0842		

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F 0842 SS=E	Continued from page 181 483.20(f)(5), 483.70(h)(1)-(5) Resident Records - Identifiable Information §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(h) Medical records. §483.70(h)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(h)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;	F 0842	R66 test results were received on 12/19/24. R17 and R34 appointments and medical records were audited and appointments made as needed. Other residents who have had procedures or tests at the hospital within a lookback of 3 months will be audited for documentation. DON or designee will audit residents who have had procedures or tests at an outside location to ensure facility completely and accurately documents as appropriate weekly for 4 weeks then monthly for 2 months. Medical Records clerk will be educated on the expectation of ensuring facility completely and accurately documents external procedures and tests by DON or designee. Audit results will be reviewed through the monthly QAPI process/meeting.	Completion Date: **02/11/2025** Status: **APPROVED** Date: **01/28/2025**

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F 0842 SS=E	Continued from page 182 (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(h)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(h)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.	F 0842		

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F 0842 SS=E	Continued from page 183 This REQUIREMENT is not met as evidenced by:	F 0842		

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F 0842 SS=E	Continued from page 184 Based on review of facility policy, review of clinical records and staff interview, it was determined that the facility failed to make certain that medical records on each resident are complete and accurately documented for three of six residents (Resident R17, R34, and R66). Findings include: A review of the facility policy "Documentation in Medical Record" dated 12/3/24, and previously dated 9/12/24, indicated that each resident's medical record shall contain an accurate representation of the actual experiences of the resident and include enough information to provide a picture of the resident's progress through complete, accurate, and timely documentation. Review of the clinical record indicated that Resident R17 was admitted to the facility on 7/25/24, with diagnoses of Chronic Obstructive Pulmonary Disease (an ongoing lung condition caused by damage to the lungs), Obstructive Sleep Apnea (a	F 0842		

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F 0842 SS=E	Continued from page 185 sleep disorder in which the throat muscles relax and block the airway, causing breathing to become restricted and briefly stop), and respiratory failure. Review of Resident R17's MDS dated 8/1/24, indicated the diagnoses were current. Review of Resident R17's clinical record indicated he was transferred out to the hospital on the following dates for respiratory distress. -9/9/24 -9/15/24 -9/18/24 -9/28/24 -10/30/24 Review of Resident R17's clinical record on 12/17/24, at 9:30 a.m. failed to include Resident R17's hospital discharge summary from the above hospital stays. During an interview on 12/18/24, at 1:46 p.m. the Nursing Home Administrator confirmed that the	F 0842		

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F 0842 SS=E	Continued from page 186 facility failed to make certain that medical records were complete and accurately documented for Resident R17. Review of the clinical record revealed that Resident R34 was admitted to the facility on 9/9/24 from a hospital. Review of Resident 34's MDS dated 9/16/24, indicated diagnoses of high blood pressure, diabetes (a disorder in which the body has high sugar levels for prolonged periods of time), and pain. Review of medical records revealed that Resident R34 had a physician's order dated 9/20/24, indicated to complete a CBC (Complete Blood Count- a group of blood tests that measure the number and size of the different cells in your body), and BMP (Basal Metabolic Panel- a blood test that measures the body's metabolism). Review of medical records revealed that Resident R34 had a physician's order dated 12/4/24,	F 0842		

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F 0842 SS=E	Continued from page 187 indicated to complete a CBC, and BMP. Review of medical records revealed that Resident R34 had a physician's order dated 12/9/24, indicated to complete a BMP, and an H and H level (a blood test that provides information about the oxygen-carrying capacity of the blood). Review of medical records on 12/18/24, failed to reveal any hospital records, or lab results for Resident R34. During an interview on 12/19/24, at 9:36 a.m. a request was made to Nursing Home Administrator (NHA) to provide Resident R34's hospital records and lab results. During an observation, the Facility was unable to produce the requested documents for Resident R34 until 12/19/24, at 2:02 p.m. During an interview on 12/19/24 at 2:45 p.m. NHA confirmed that the facility failed to make certain that	F 0842		

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F 0842 SS=E	Continued from page 188 medical records were complete and accurately documented for Resident R34. Review of Resident R66's clinical record indicated the resident was admitted to the facility on 9/16/22. Review of Resident R66's MDS dated 11/5/24, indicated diagnoses of high blood pressure, depression, and cerebral infarction (necrotic tissue in the brain resulting loss of blood and oxygen to the brain). Review of medical records revealed that Resident R66 had a physician's order dated 7/26/24, indicated a diagnostic mammogram (an x-ray image of the breast to screen for cancer) was ordered. Review of medical records on 12/17/24, failed to reveal any hospital mammogram results for Resident R66. During an interview on 12/17/24, at 1:33 p.m. a request was made to Ward Clerk Employee E5 to	F 0842		

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F 0842 SS=E	Continued from page 189 provide Resident R66's mammogram results. During an observation, the Facility was unable to produce the requested document for Resident R66 until 12/19/24, at 2:15 p.m. in which it was faxed from the hospital. During an interview on 12/20/24, at 1:33 p.m. the Director of Nursing confirmed that the facility failed to make certain that medical records were complete and accurately documented for Resident R66. 28 Pa. Code: 211.5(f)(g)(h) Clinical records.	F 0842		
F 0849 SS=D		F 0849		

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F 0849 SS=D	Continued from page 190 483.70(n)(1)-(4) Hospice Services §483.70(n) Hospice services. §483.70(n)(1) A long-term care (LTC) facility may do either of the following: (i) Arrange for the provision of hospice services through an agreement with one or more Medicare-certified hospices. (ii) Not arrange for the provision of hospice services at the facility through an agreement with a Medicare-certified hospice and assist the resident in transferring to a facility that will arrange for the provision of hospice services when a resident requests a transfer. §483.70(n)(2) If hospice care is furnished in an LTC facility through an agreement as specified in paragraph (o)(1)(i) of this section with a hospice, the LTC facility must meet the following requirements: (i) Ensure that the hospice services meet professional standards and principles that apply to individuals providing services in the facility, and to the timeliness of the services. (ii) Have a written agreement with the hospice that is signed by an authorized representative of the hospice and an authorized representative of the LTC facility before hospice care is furnished to any resident. The written agreement must set out at least the following: (A) The services the hospice will provide. (B) The hospice's responsibilities for determining the appropriate hospice plan of care as specified in §418.112 (d) of this chapter.	F 0849	R12 diagnosis and care plan were updated to reflect the hospice diagnosis and information. Other current hospice residents will be audited by DON or designee for documentation. DON or designee will audit hospice residents to ensure facility documents diagnosis and information in Care Plan as appropriate, in house diagnosis order and coordination of services weekly for 4 weeks then monthly for 2 months. Licensed nurses will be educated on the expectation of ensuring facility documents hospice diagnosis and information in care plan as appropriate by DON or designee. Audit results will be reviewed through the monthly QAPI process/meeting.	Completion Date: **02/11/2025** Status: **APPROVED** Date: **01/28/2025**

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F 0849 SS=D	Continued from page 191 (C) The services the LTC facility will continue to provide based on each resident's plan of care. (D) A communication process, including how the communication will be documented between the LTC facility and the hospice provider, to ensure that the needs of the resident are addressed and met 24 hours per day. (E) A provision that the LTC facility immediately notifies the hospice about the following: (1) A significant change in the resident's physical, mental, social, or emotional status. (2) Clinical complications that suggest a need to alter the plan of care. (3) A need to transfer the resident from the facility for any condition. (4) The resident's death. (F) A provision stating that the hospice assumes responsibility for determining the appropriate course of hospice care, including the determination to change the level of services provided. (G) An agreement that it is the LTC facility's responsibility to furnish 24-hour room and board care, meet the resident's personal care and nursing needs in coordination with the hospice representative, and ensure that the level of care provided is appropriately based on the individual resident's needs. (H) A delineation of the hospice's responsibilities, including but not limited to, providing medical direction and management of the patient; nursing; counseling (including spiritual, dietary, and bereavement); social work; providing medical supplies, durable medical equipment, and	F 0849		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395471	A. BLDG: __00_____ B. WING: _____	12/20/2024

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F 0849 SS=D	Continued from page 192 drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related conditions; and all other hospice services that are necessary for the care of the resident's terminal illness and related conditions. (I) A provision that when the LTC facility personnel are responsible for the administration of prescribed therapies, including those therapies determined appropriate by the hospice and delineated in the hospice plan of care, the LTC facility personnel may administer the therapies where permitted by State law and as specified by the LTC facility. (J) A provision stating that the LTC facility must report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by hospice personnel, to the hospice administrator immediately when the LTC facility becomes aware of the alleged violation. (K) A delineation of the responsibilities of the hospice and the LTC facility to provide bereavement services to LTC facility staff. §483.70(n)(3) Each LTC facility arranging for the provision of hospice care under a written agreement must designate a member of the facility's interdisciplinary team who is responsible for working with hospice representatives to coordinate care to the resident provided by the LTC facility staff and hospice staff. The interdisciplinary team member must have a clinical background, function within their State scope of practice act, and have the ability to assess the resident or have access to someone that has the skills and	F 0849		

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F 0849 SS=D	Continued from page 193 capabilities to assess the resident. The designated interdisciplinary team member is responsible for the following: (i) Collaborating with hospice representatives and coordinating LTC facility staff participation in the hospice care planning process for those residents receiving these services. (ii) Communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the patient and family. (iii) Ensuring that the LTC facility communicates with the hospice medical director, the patient's attending physician, and other practitioners participating in the provision of care to the patient as needed to coordinate the hospice care with the medical care provided by other physicians. (iv) Obtaining the following information from the hospice: (A) The most recent hospice plan of care specific to each patient. (B) Hospice election form. (C) Physician certification and recertification of the terminal illness specific to each patient. (D) Names and contact information for hospice personnel involved in hospice care of each patient. (E) Instructions on how to access the hospice's 24-hour on-call system. (F) Hospice medication information specific to each patient. (G) Hospice physician and attending physician (if any)	F 0849		

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F 0849 SS=D	Continued from page 194 orders specific to each patient. (v) Ensuring that the LTC facility staff provides orientation in the policies and procedures of the facility, including patient rights, appropriate forms, and record keeping requirements, to hospice staff furnishing care to LTC residents. §483.70(n)(4) Each LTC facility providing hospice care under a written agreement must ensure that each resident's written plan of care includes both the most recent hospice plan of care and a description of the services furnished by the LTC facility to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, as required at §483.24. This REQUIREMENT is not met as evidenced by:	F 0849		

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F 0849 SS=D	Continued from page 195 Based on a review of facility policy, resident clinical records, and staff interview, it was determined the facility failed to obtain a diagnosis, and order for hospice services and to ensure the coordination of hospice services with facility services to meet the needs of each resident for end-of-life care for one of two residents (Resident R12). Findings include: Review of the facility policy "Providing End of Life Care" dated 12/3/24, and previously dated 9/12/24, indicated that if a resident chooses hospice services (care for terminally ill residents) the plan of care will include the resident's underlying diagnoses. The facility will maintain communication with Hospice. Review of the clinical record revealed that Resident R12 was admitted to the facility on 8/2/12. Review of Resident 12's MDS (Minimum Data Set-periodic assessment of resident care needs) dated 11/15/24, indicated diagnoses of high blood	F 0849		

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F 0849 SS=D	Continued from page 196 pressure, diabetes (a disorder in which the body has high sugar levels for prolonged periods of time), and hypokalemia (low potassium levels in the blood). Section O - Special Treatments, Procedures, and Programs indicated hospice care while a resident. Review of Resident R12's clinical record revealed a physician order dated 11/12/24, for a referral for hospice services, but did not include a diagnosis related to the need of hospice services, or to admit the resident to hospice services. Review of Resident R12's current comprehensive care plan failed to indicate a plan of care by the facility that displayed the coordination of hospice services by failing to included contact information for the hospice agency and how to access the hospice's 24 hour on-call system. During an interview on 12/19/24, at 11:45 a.m. Registered Nurse Assessment Coordinator Employee E2 confirmed that the facility failed to obtain a diagnosis and order for hospice services	F 0849		

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F 0849 SS=D	Continued from page 197 and to ensure the coordination of hospice services with facility services to meet the needs of each resident for end-of-life care for one of two hospice residents (R12). 28 Pa. Code 211.2(a) Physician services 28 Pa. Code 211.11(d) Resident care plan	F 0849		
F 0880 SS=D	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;	F 0880	R84 suffered no ill effects from cited concern. Nursing staff will be educated on proper hand hygiene and doffing of PPE by DON or designee. Hand hygiene and doffing of PPE audits will be conducted weekly x4 weeks then monthly x2 months by DON/designee. There are two staff being observed for hand hygiene/PPE doffing for each audit. There will be one dressing change observed each audit. Audit results will be reviewed through the monthly QAPI process/meeting.	Completion Date: **02/11/2025** Status: **APPROVED** Date: **01/28/2025**

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F 0880 SS=D	Continued from page 198 §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; (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.	F 0880		

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F 0880 SS=D	Continued from page 199 Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by:	F 0880		

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F 0880 SS=D	Continued from page 200 Based on review of facility policy, observations, and staff interviews, it was determined that the facility failed to implement infection control practices to prevent cross contamination during a dressing change for one of three residents (Resident R84) Findings include: A review of the facility policy "Enhanced Barrier Precautions", last reviewed 12/3/24, indicated enhanced barrier precautions will be implemented for residents who have a wound. Review of the Center for Disease Control "How to Safely Remove Personal Protective Equipment (PPE)" indicated all PPE is removed before exiting the patient room except a respirator, if worn. The first step of doffing PPE is removing the gown. Then the gloves are removed without contaminating your hands. A review of the facility procedure "Hand Hygiene" last reviewed 12/3/24, indicated staff must perform	F 0880		

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F 0880 SS=D	Continued from page 201 hand hygiene when indicated, using proper technique consistent with accepted standards of practice. Handwashing should take about 20 seconds and a clean towel is used to turn off the faucet. Review of the admission record indicated Resident R84 was admitted to the facility on 10/15/24. Review of R84's Minimum Data Set (MDS-periodic assessment of care needs) dated 10/22/24, included diagnoses of anemia (the blood doesn't have enough healthy red blood cells), cellulitis (infection of skin), and unstageable pressure ulcer (full-thickness skin and muscle loss, with slough (soft, yellowish, or white dead tissue) or eschar (black, hard dead tissue) obstructing the wound bed.) Review of Resident 84's physician order dated 12/18/24, indicated to cleanse right medial and posterior thigh wounds with wound cleanser, apply alginate (highly absorbent wound care product from natural seaweed extracts) to wound base, add dry	F 0880		

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F 0880 SS=D	Continued from page 202 gauze to help pack wounds. Cover with abdominal pads. During an observation of Resident R84's wound dressing change on 12/19/24, at 10:55 a.m. Licensed Practical Nurse, Employee E24 failed to wash her hands longer than 20 seconds and failed to use a barrier to turn off the faucet on four separate occasions. Nurse Aide, Employee E28 removed her gloves prior to removing her gown while doffing of PPE. During an interview on 12/19/24, at 11:28 a.m. Licensed Practical Nurse Employee E24 confirmed the facility failed to implement infection control practices to prevent cross contamination during a dressing change for one of three residents (Resident R84). 28 Pa. code: 201.14 (a) Responsibility of licensee. 28 Pa. Code: 201.18 (b) (1) (e) (1) Management. 28 Pa. Code: 211.10 (d) Resident care policies. 28 Pa. Code: 211.12 (d) (1) (2) (5) Nursing	F 0880		

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F 0880 SS=D	Continued from page 203 services.	F 0880		

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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	A member of the community will participate in quarterly infection control meetings. Signature sheet was revised to show this participation. Community member participation will be audited monthly x 3 months. Audit results will be reviewed through the monthly QAPI process	Completion Date: **02/11/2025** Status: **APPROVED** Date: **01/28/2025**

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

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P 1020	Continued from page 1 Based on state regulations, staff interview, and review of the facility's Infection Control Committee Meeting attendance records, it was determined that the facility failed to ensure that all the required nine multidisciplinary members (community member) were present at the Infection Control Committee Meetings for four of four quarters (Quarters 1, 2, 3, and 4 of 2024). Findings include: Review of Act 52 (The Act of March 20, 2002, P.L. 154, No. 13), known as the Medical Care Availability and Reduction of Error (MCARE) Act, Chapter 4, Section 403(1) Infection Control plan states, "A health care facility... shall develop and implement an internal infection control plan that shall include... a multidisciplinary committee including representatives from each of the following if applicable to that specific health care facility." A review of the applicable members at infection control meetings include medical staff, administration, laboratory personnel, nursing staff,	P 1020		

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P 1020	Continued from page 2 pharmacy staff, physical plant personnel, patient safety officer, a community member, and a member of the infection control team. During an interview on 12/17/24, at 1:33 p.m. Infection Preventionist Employee E3 stated the facility has the attendees for the Infection Control meetings sign in on the Quality Assurance (QA) meeting form. During an interview on 12/19/24, at 10:05 a.m. the Nursing Home Administrator (NHA) stated that the facility does not have a member from the community attend the Infection Control meetings. During an interview on 12/19/24, at 10:05 a.m. the NHA confirmed that the facility failed to ensure that all the required nine multidisciplinary members (community member) were present at the Infection Control Committee Meetings for four of four quarters (Quarters 1, 2, 3, and 4 of 2024).	P 1020		

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P 5520	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	The residents had no negative outcome from not meeting a minimum of one nurses aide per 10 residents on the day shift, one nurses aide per 15 residents on night shift. We are working with a local school to start offering CNA classes. The DON or designee will provide the staffing coordinator with education on the Pennsylvania staffing requirements. Staffing coordinator or designee will audit the ratios daily times 4 weeks, and monthly times 1 month. Audit results will be reviewed through the monthly QAPI process/meeting.	Completion Date: **02/11/2025** Status: **APPROVED** Date: **01/28/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395471	A. BLDG: 00 B. WING:	12/20/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
ARMSTRONG REHABILITATION AND NURSING CENTER STATE LICENSE NUMBER: **530602**	**265 S MCKEAN STREET KITTANNING, PA 16201**

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P 5520	Continued from page 4 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 ten residents during the day shift for one of 21 days (11/29/24), and failed to provide a minimum of one nurse aide per 15 residents on the night shift for one of 21 days (11/28/24). Findings include: Review of facility census data, nursing time schedules from 11/24/24 through 12/7/24, and 12/13/24 through 12/19/24, revealed the following nurse aide staffing shortages. Day shift: Date Census Full time equivalents (FTE) required FTE present 11/29/24 87 8.7 8.5	P 5520		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395471	A. BLDG: __00_____ B. WING: _____	12/20/2024

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P 5520	Continued from page 5 Night shift: Date Census FTE required FTE present 11/28/24 87 5.8 4.09 During an interview on 12/20/24, at 1:39 p.m. Director of Nursing confirmed that the facility failed to provide a minimum of one nurse aide per 10 residents during the day, and one nurse aide per 15 residents on the night shift, with no additional excess higher-level staff to compensate this deficiency.	P 5520		
P 5530		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 6 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	The residents had no negative outcome from not meeting a minimum of one LPN on one shift. We are working on a relationship with a local school to try to procure staff. The DON or designee will provide the staffing coordinator with education on the Pennsylvania staffing requirements. Staffing coordinator or designee will audit the ratios daily times 4 weeks, and monthly times 1 month. Audit results will be reviewed through the monthly QAPI process/meeting.	Completion Date: **02/11/2025** Status: **APPROVED** Date: **01/28/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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P 5530	Continued from page 7 Based on review of nursing time schedules and staff interview it was determined that the facility administrative staff failed to provide a minimum of one licensed practical nurse (LPN) per 25 residents during the day shift on one of 21 days (12/7/24). Findings include: Review of facility census data, nursing time schedules from 11/24/24 through 12/7/24, and 12/13/24 through 12/19/24, revealed the following LPN staffing shortages. Day shift: Date Census FTE required FTE present 12/7/24 88 3.52 3.18 During an interview on 12/20/24, at 1:39 p.m. Director of Nursing confirmed that the facility failed	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 8 to provide a minimum of one LPN per 25 residents during the day shift, with no additional excess higher-level staff to compensate this deficiency.	P 5530		

Certified End Page

ARMSTRONG REHABILITATION AND NURSING CENTER

STATE LICENSE NUMBER: 530602

SURVEY EXIT DATE: 12/20/2024

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

Jeanne Parisi
Deputy Secretary for Quality Assurance

Debra L. Bogen, MD, FAAP
Secretary of Health

Pennsylvania
Department of Health

THIS IS A CERTIFICATION PAGE

PLEASE DO NOT DETACH

THIS PAGE IS NOW PART OF THIS SURVEY