STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395552	A. BLDG: 00 B. WING:	12/30/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
BETHLEN HOME OF THE HUNGARIAN REFORMED FEDERATION OF AMERICA STATE LICENSE NUMBER: **021402**	**66 CAREY SCHOOL ROAD LIGONIER, PA 15658**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0000	INITIAL COMMENT Based on an abreviated complaint survey completed on December 30, 2024, it was determined that The Bethlen Home of the Hungarian Reformed Federation of America was not in compliance with the following requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities and the 28 PA Code, Commonwealth of Pennsylvania Long Term Care Licensure Regulations.	F 0000		
F 0658 SS=D		F 0658		

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 0658 SS=D	Continued from page 1 483.21(b)(3)(i) Services Provided Meet Professional Standards §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by:	F 0658	Resident 2 suffered no ill effects as a result of failure to document the Registered Nurse assessment. Education for Registered Nurses and Licensed Practical nurses will be conducted on 1/14/2025 regarding documentation of the Registered Nurse assessment. Review of change in condition will during the clinical portion of the Interdisciplinary Team meeting to ensure appropriate registered nurse assessments occurred appropriately and timely. Weekly audits for accuracy by Director of Nursing or designee. These audits will be conducted weekly, and the results of these audits will be reviewed at Quality Assurance and Process Improvement meetings until substantial compliance is achieved.	Completion Date: **02/13/2025** Status: **APPROVED** Date: **01/14/2025**

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F 0658 SS=D	Continued from page 2 Based on review of Pennsylvania's Nursing Practice Act and clinical records, as well as staff interviews, it was determined that the facility failed to ensure that an assessment was completed by a professional (registered) nurse after an injury occurred for one of 10 residents reviewed (Resident 2). Findings include: The Pennsylvania Code, Title 49, Professional and Vocational Standards, State Board of Nursing, 21.11 (a)(1)(2)(4) indicated that the registered nurse was to collect complete and ongoing data to determine nursing care needs, analyze the health status of individuals and compare the data with the norm when determining nursing care needs, and carry out nursing care actions that promote, maintain, and restore the well-being of individuals. A facility policy, dated November 27, 2024, regarding accidents and incidents, indicated that falls require an incident and accident reports, with the	F 0658		

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F 0658 SS=D	Continued from page 3 nurse entering the information to the appropriate form or system within 24 hours of the occurrence and will document all pertinent information. The supervisors or other designee will be notified of the incident or accident. Any injuries will be assessed by the licensed nurse or practitioner, and the affected individual will not move until safe to do so. A quarterly minimum data set (MDS) assessment (mandated to assess the resident abilities and care needs) for Resident 2, dated October 30, 2024, revealed that the resident was usually understood and could usually understand others, was moderately cognitively impaired, required supervision and touch assistance with ambulation and transfers, and had wandering behaviors. A witnessed fall investigation and nurse's note completed by Licensed Practical Nurse 2, dated December 6, 2024, revealed that while receiving shift report Resident 2 attempted to sit in front of the piano in front of the nurse's station, but missed the stool and landed on her buttocks on the floor.	F 0658		

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F 0658 SS=D	Continued from page 4 There was no documented evidence in Resident 2's clinical record to indicate that a registered nurse assessment was conducted for Resident 2's fall. An interview with Licensed Practical Nurse 2 on December 30, 2024, at 5:40 p.m. revealed that he and the other licensed practical nurse who was going off shift witnessed the fall, and they responded immediately, but does not recall a registered nurse assessing Resident 2. An interview with Director of Nursing on December 30, 2024, at 2:27 p.m. confirmed that there was no documented evidence that a registered nurse assessment was completed after Resident 2 fell on December 6, 2024, and there should have been. She explained that there have been many call offs, and she has been covering shifts and working the floor in addition to her Director of Nursing duties 28 Pa. Code 211.12(d)(1)(3)(5) Nursing Services.	F 0658		

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F 0658 SS=D	Continued from page 5	F 0658		
F 0842 SS=D	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	F 0842	Resident 3 suffered no ill effects as a result of failure to document the incident and accident or failure to conduct the Registered Nurse assessment. Education for Registered Nurses and Licensed Practical nurses will be conducted on 1/14/2025 regarding documentation of the incidents and accidents and documentation of the Registered Nurse assessment. Review of change in condition will during the clinical portion of the Interdisciplinary Team meeting to ensure documentation of incidents and accidents and the registered nurse assessments occurred appropriately and timely. Weekly audits for accuracy by Director of Nursing or designee. These audits will be conducted weekly, and the results of these audits will be reviewed at Quality Assurance and Process Improvement meetings until substantial compliance is achieved.	Completion Date: **02/13/2025** Status: **APPROVED** Date: **01/14/2025**

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F 0842 SS=D	Continued from page 6 permitted by and in compliance with 45 CFR 164.506; (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=D	Continued from page 7 This REQUIREMENT is not met as evidenced by:	F 0842		

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F 0842 SS=D	Continued from page 8 Based on review of clinical records, as well as resident and staff interviews, it was determined that the facility failed to maintain clinical records that were complete and accurately documented for one of four residents reviewed (Resident 3). Findings include: A facility policy, dated November 27, 2024, regarding accidents and incidents, indicated that falls require an incident and accident reports, with the nurse entering the information to the appropriate form or system within 24 hours of the occurrence and will document all pertinent information. The documentation should include the date, time, nature of the incident, location, initial findings, immediate interventions, notifications and orders obtained or follow-up interventions. A quarterly minimum data set (MDS) assessment (mandated to assess the resident abilities and care needs) for Resident 3, dated October 21, 2024,	F 0842		

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F 0842 SS=D	Continued from page 9 indicated that the resident was sometimes able to understand others; was sometimes understood by others; was severely cognitively impaired; required supervision and touch assistance with ambulation, bed mobility, and transfers; required substantial assistance with hygiene, toileting, and dressing;had diagnoses that included Alzheimer's disease and wandering behaviors. A care plan for Resident 3, dated February 5, 2024, indicated that she was a risk for falls or injury. A fall investigation by Licensed Practical Nurse 1, dated December 24, 2024, revealed that Resident 3 was walking behind staff after completion of morning care. Resident 3 fell backwards onto her buttocks in the bathroom doorway with her walker still standing. A review of Resident 3's clinical record revealed no documented evidence of the resident's fall or an assessment by a registered nurse. Interview with Licensed Practical Nurse 1, dated December 30, 2024, at 3:33 p.m., indicated that	F 0842		

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F 0842 SS=D	Continued from page 10 she and the registered nurse on duty assessed Resident 3 following the fall on December 24, 2024. She confirmed that she did not write an additional nursing note in the clinical record because the investigation should have linked to the progress notes. The registered nurse should have written an additional note following the incident. Interview with the Director of Nursing on December 30, 2024, at 2:27 p.m. confirmed that there was no documented evidence of Resident 3's fall or assessment by a registered nurse in the clinical record, and there should have been. 28 Pa. Code 211.5(f) Clinical Records 28 Pa. Code 211.12(d)(5) Nursing Services.	F 0842		

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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 facility will continue to take measures to adequately provide staff to ensure the needs of residents are met. The facility will continue to take measures to adequately provide staff to meet the required nurse aide to resident ratios on all shifts. The Director of Nursing or designee will provide re-education on minimum staffing ratios to Registered Nurse Supervisors, Human Resources, and Scheduling who are responsible to maintain adequate staffing and staffing ratios. Director of Nursing or designee will re-educate Human Resources, Scheduler and Registered Nurse supervisors of protocols for calling in staff related to call offs. The Director of Nursing or designee will audit the daily schedules to ensure that the minimum number of staff to resident ratios have been scheduled and will audit that protocols were followed after a call off occurred. These audits will be conducted weekly, and the results of these audits will be reviewed at Quality Assurance and Process Improvement meetings until substantial compliance is achieved.	Completion Date: **02/13/2025** Status: **APPROVED** Date: **01/14/2025**

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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P 5520	Continued from page 1 Based on review of nursing schedules and staffing information furnished by the facility, as well as staff interview, it was determined that the facility failed to ensure a minimum of one nurse aide (NA) per 10 residents on the day shift for two of 21 days reviewed for December 8 through 28, 2024; and to ensure a minimum of one NA per 15 residents on the overnight shift for four of 21 days for December 8 through 28, 2024. Findings include: Review of facility census data indicated that on December 19, 2024, the facility census was 71, which required 7.10 NA's during the day shift. Review of the nursing time schedules revealed 6.47 NA's provided care on the day shift on December 19, 2024. Review of facility census data indicated that on December 28, 2024, the facility census was 65, which required 6.50 NA's during the day shift. Review of the nursing time schedules revealed 5.63 NA's provided care on the day shift on December	P 5520		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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P 5520	Continued from page 2 28, 2024. Review of facility census data indicated that on December 15, 2024, the facility census was 67, which required 4.47 NA's during the overnight shift. Review of the nursing time schedules revealed 3.24 NA's provided care on the overnight on December 15, 2024. Review of facility census data indicated that on December 19, 2024, the facility census was 71, which required 4.73 NA's during the overnight shift. Review of the nursing time schedules revealed 4.38 NA's provided care on the overnight shift on December 19, 2024. Review of facility census data indicated that on December 20, 2024, the facility census was 72, which required 4.80 NA's during the overnight shift. Review of the nursing time schedules revealed 4.29 NA's provided care on the overnight shift on December 20, 2024. Review of facility census data indicated that on December 21, 2024, the facility census was 71 which required 4.73 NA's during the overnight shift. Review of the nursing time schedules revealed 4.22 NA's provided care on the overnight shift on December 21, 2024.	P 5520		

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P 5520	Continued from page 3 No additional excess higher-level staff were available to compensate for these deficiencies. Interview with the Nursing Home Administrator on December 30, 2024, at 5:55 p.m. confirmed that the facility did not meet the required NA-to-resident staffing ratios for the days listed above.	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 4 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 facility will continue to take measures to adequately provide staff to ensure the needs of residents are met. The facility will continue to take measures to adequately provide staff to meet the required Licensed Practical Nurse to resident ratios on the day shift. The Director of Nursing or designee will provide re-education on minimum staffing ratios to Registered Nurse Supervisors, Human Resources, and Scheduling who are responsible to maintain adequate staffing and staffing ratios. Director of Nursing or designee will re-educate Human Resources, Scheduler and Registered Nurse supervisors of protocols for calling in staff related to call offs. The Director of Nursing or designee will audit the daily schedules to ensure that the minimum number of staff to resident ratios have been scheduled and will audit that protocols were followed after a call off occurred. These audits will be conducted weekly, and the results of	Completion Date: **02/13/2025** Status: **APPROVED** Date: **01/14/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395552	A. BLDG: __00_____ B. WING: _____	12/30/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
BETHLEN HOME OF THE HUNGARIAN REFORMED FEDERATION OF AMERICA STATE LICENSE NUMBER: **021402**	**66 CAREY SCHOOL ROAD LIGONIER, PA 15658**

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P 5530	Continued from page 5	P 5530	these audits will be reviewed at Quality Assurance and Process Improvement meetings until substantial compliance is achieved.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395552	A. BLDG: 00 B. WING:	12/30/2024

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P 5530	Continued from page 6 Based on review of nursing schedules and staffing information furnished by the facility, as well as staff interview, it was determined that the facility failed to ensure a minimum of one licensed practical nurse (LPN) per 30 residents on the evening shift for two of 21 days for December 8 through 28, 2024. Findings include: Review of facility census data indicated that on December 20, 2024, the facility census was 72, which required 2.40 LPN's during the day shift. Review of the nursing time schedules revealed 2.14 LPN's provided care on the evening shift on December 20, 2024. Review of facility census data indicated that on December 28, 2024, the facility census was 65, which required 2.17 LPN's during the day shift. Review of the nursing time schedules revealed 2.13 LPN's provided care on the evening shift on December 28, 2024. No additional excess higher-level staff were	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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NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
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P 5530	Continued from page 7 available to compensate for these deficiencies. Interview with the Nursing Home Administrator on December 30, 2024, at 5:55 p.m. confirmed that the facility did not meet the required LPN-to-resident staffing ratios for the days listed above.	P 5530		

Certified End Page

BETHLEN HOME OF THE HUNGARIAN REFORMED FEDERATION OF AMERICA

STATE LICENSE NUMBER: 021402

SURVEY EXIT DATE: 12/30/2024

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
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