STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395592	A. BLDG: 00 B. WING:	01/15/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
HAIDA NURSING AND REHAB STATE LICENSE NUMBER: **340102**	**397 THIRD AVENUE EXTENSION** **HASTINGS, PA 16646**

(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 complaint survey completed on January 15, 2025, it was determined that Haida Nursing and Rehab 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 0580 SS=D		F 0580		

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395592	A. BLDG: 00 B. WING:	01/15/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
HAIDA NURSING AND REHAB STATE LICENSE NUMBER: **340102**	**397 THIRD AVENUE EXTENSION** **HASTINGS, PA 16646**

(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 0580 SS=D	Continued from page 1 483.10(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	1. Resident 7 remains in the facility; residents medical record was reviewed by the physician and medications remain appropriate. Family member is aware of all medication's orders. 2. The Director of Nursing/Designee will review progress notes and 24-hour report daily to ensure notification to resident's representatives are informed of any medication changes and document the notification in the medical record. 3. The Director of Nursing/Designee will educate the Registered nurses on the importance of notifying Resident's representative on any medication changes, and documenting in the medical record of any medication changes.	Completion Date: **02/11/2025** Status: **APPROVED** Date: **01/30/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395592	A. BLDG: 00 B. WING:	01/15/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
HAIDA NURSING AND REHAB STATE LICENSE NUMBER: **340102**	**397 THIRD AVENUE EXTENSION HASTINGS, PA 16646**

(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 0580 SS=D	Continued from page 2 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	4. The Director of Nursing/Designee will audit daily by reviewing progress notes and the 24-hour report to ensure notification to Resident's representative on medication changes and documentation was completed on any medication changes. This audit will be completed daily 5 times for two weeks, then three times a week times 2 weeks, then weekly times two weeks, then monthly times two months. Results of the audits will be reviewed at the Quality Assurance meetings until substantial compliance has been met. 5. The completion date will be 02/11/2025.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395592	A. BLDG: __00_____ B. WING: _____	01/15/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
HAIDA NURSING AND REHAB STATE LICENSE NUMBER: **340102**	**397 THIRD AVENUE EXTENSION HASTINGS, PA 16646**

(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 0580 SS=D	Continued from page 3 Based on review of policies and clinical records, as well as staff interviews, it was determined that the facility failed to ensure that the resident's representative/interested family member was notified timely about the need to alter treatment/changes in physician's orders for one of seven residents reviewed (Resident 7). Findings include: The facility's policy regarding charting and documentation, dated July 25, 2024, indicated that documentation of procedures and treatments will include care-specific details, including notification of family, physician, or other staff, if indicated. A quarterly Minimum Data Set (MDS) assessment (a federally-mandated assessment of a resident's abilities and care needs) for Resident 7, dated December 2, 2024, revealed that the resident was understood, understands with a Brief Interview for Mental Status score (BIMs - intended to determine	F 0580		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395592	A. BLDG: 00 B. WING:	01/15/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
HAIDA NURSING AND REHAB STATE LICENSE NUMBER: **340102**	**397 THIRD AVENUE EXTENSION HASTINGS, PA 16646**

(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 0580 SS=D	Continued from page 4 the resident's attention, orientation and ability to register and recall new information and whether the resident has signs and symptoms of delirium) of 10, indicating that the resident was moderately impaired, and had a diagnosis which included Parkinson's disease and dementia. A care plan for the resident, dated August 27, 2021, revealed that the resident has an Advanced Directive (a written statement of a person's wishes regarding medical treatment) and staff were to keep the family informed of changes in condition. The resident's clinical record revealed that Resident Family Member 1 was the resident's power of attorney (a person legally authorized to make decisions for someone else), emergency contact, and was an interested family member. Physician's orders for Resident 7, dated December 17, 2024, included an order for the resident to receive one 20 milligram (mg) tablet of Paxil (an antidepressant) one time a day for psychosis (a set of symptoms that affect a person's ability to distinguish reality from what is not real).	F 0580		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395592	A. BLDG: 00 B. WING:	01/15/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
HAIDA NURSING AND REHAB STATE LICENSE NUMBER: **340102**	**397 THIRD AVENUE EXTENSION HASTINGS, PA 16646**

(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 0580 SS=D	Continued from page 5 Physician's orders for Resident 7, dated January 2, 2025, included an order for the resident to receive one 25 mg capsule of Anafranil (an antidepressant medication that treats obsessive-compulsive disorder) at bedtime for obsessive-compulsive disorder. There was no documented evidence that Resident 7 instructed the facility not to contact Resident Family Member 1, and no documented evidence that Resident Family Member 1 was notified about the physician's orders on December 17, 2024, and January 2, 2025. Interview with the Director of Nursing on January 15, 2025, at 2:25 p.m. confirmed that Resident Family Member 1 was not notified about the above changes in Resident 7's treatment. 28 Pa. Code 201.14(a) Responsibility of Licensee. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing Services.	F 0580		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395592	A. BLDG: __00_____ B. WING: _____	01/15/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
HAIDA NURSING AND REHAB STATE LICENSE NUMBER: **340102**	**397 THIRD AVENUE EXTENSION HASTINGS, PA 16646**

(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 0684 SS=D		F 0684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395592	A. BLDG: 00 B. WING:	01/15/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
HAIDA NURSING AND REHAB STATE LICENSE NUMBER: **340102**	**397 THIRD AVENUE EXTENSION HASTINGS, PA 16646**

(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 0684 SS=D	Continued from page 7 483.25 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	1. Resident 2 no longer resides in the facility 2. Residents that have a change in condition will have a full assessment completed by the Registered Nurse with documentation in the medical record. The Registered nurse will immediately call the physician informing him of the assessment and the change in condition. The Registered nurse will then implement orders received and update the resident's representative of orders. 3. The Director of Nursing and the Registered Nurses will be educated by the facility Consultant/Designee on Assessing residents with change of conditions and following the physician's orders, along with implementing of physician's orders, updating resident's representatives and completed documentation in the medical record.	Completion Date: **02/11/2025** Status: **APPROVED** Date: **01/30/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395592	A. BLDG: __00_____ B. WING: _____	01/15/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
HAIDA NURSING AND REHAB STATE LICENSE NUMBER: **340102**	**397 THIRD AVENUE EXTENSION HASTINGS, PA 16646**

(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 0684 SS=D	Continued from page 8	F 0684	4. An audit will be completed by the facility consultant/Designee on any resident with a change of condition to ensure a complete assessment was performed, with physician notification, orders implemented, complete documentation in the medical record, and resident representative updated. This audit will be completed daily 5 times a week times two weeks, then three times a week times 2 weeks, then weekly times two weeks, then monthly times two months. Results of the audits will be reviewed at the Quality Assurance meetings until substantial compliance has been met. 5. The completion date will be 02/11/2025.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395592	A. BLDG: __00_____ B. WING: _____	01/15/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
HAIDA NURSING AND REHAB STATE LICENSE NUMBER: **340102**	**397 THIRD AVENUE EXTENSION HASTINGS, PA 16646**

(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 0684 SS=D	Continued from page 9 Based on review of clinical records, as well as staff interviews, it was determined that the facility failed to ensure that residents received care and treatment in accordance with professional standards of practice, by failing to ensure that physician's orders were followed for one of seven residents reviewed (Resident 2). Findings include: A quarterly Minimum Data Set (MDS) assessment (a federally-mandated assessment of a resident's abilities and care needs) for Resident 2, dated November 20, 2024, revealed that the resident was understood, could understand others, and had a Crohn's disease (a chronic inflammatory bowel disease that causes inflammation in the digestive tract), diabetes (a chronic disease that occurs when the body can not produce or use insulin properly, resulting in high blood sugar levels), and hemiplegia (a neurological condition that causes paralysis or weakness on one side of the body). The resident's	F 0684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395592	A. BLDG: __00_____ B. WING: _____	01/15/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
HAIDA NURSING AND REHAB STATE LICENSE NUMBER: **340102**	**397 THIRD AVENUE EXTENSION HASTINGS, PA 16646**

(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 0684 SS=D	Continued from page 10 clinical record revealed that Resident Family Member 2 (son) and Resident Family Member 3 (daughter-in-law) were the resident's emergency contacts and were interested family members. A nursing note for Resident 2, completed by Registered Nurse 1 and dated January 6, 2025, at 8:00 a.m., revealed that Resident Family Member 3 was at the nurses' station stating, "I want her sent out." Upon assessment, the resident was awake, alert, and oriented to self. Resident 2 stated that she was "in the emergency room." Her skin was warm and dry, her cheeks were "ruddy." She was afebrile (no increased temperature), and her vital signs were stable. Physician 2 was made aware, and no new orders were received. There was no documented evidence in the clinical record to indicate that Resident 2 was sent to the hospital per Resident Family Member 3's (daughter-in-law) request. Interview with Physician 2 on January 14, 2025, at	F 0684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395592	A. BLDG: 00 B. WING:	01/15/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
HAIDA NURSING AND REHAB STATE LICENSE NUMBER: **340102**	**397 THIRD AVENUE EXTENSION HASTINGS, PA 16646**

(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 0684 SS=D	Continued from page 11 1:42 p.m. revealed that when he received a text regarding Resident 2, he gave an order to send the resident out to the hospital at that time. He then received a text that said the resident was not going out to the hospital. He indicated that he was not aware of what changed as to why they did not send her out to the hospital at that time. Interview with the Regional Director of Clinical Services 5 on January 14, 2025, at 2:05 p.m. confirmed that the resident was not sent out to the hospital on January 6, 2025. Interview with Registered Nurse 1 on January 14, 2025, at 2:30 p.m. revealed that Resident Family Member 3 came to her and told her that she thought that the resident was having a stroke. She indicated that she went back to assess the resident and saw that the resident was not in any distress. She indicated that she did not see anything that would indicate a stroke. She indicated that before she was able to get the order in to send the resident out to the hospital the Director of Nursing came out and	F 0684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395592	A. BLDG: __00_____ B. WING: _____	01/15/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
HAIDA NURSING AND REHAB STATE LICENSE NUMBER: **340102**	**397 THIRD AVENUE EXTENSION HASTINGS, PA 16646**

(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 0684 SS=D	Continued from page 12 said that she was going to go back and assess the resident. When she came back, she said they are not sending the resident out. She indicated that she did not put the order in the electronic medical record because the Director of Nursing said that they were not sending her out, "so why put the order in." She indicated that she contacted the resident's son that she had all the paperwork and that she was going to send his mother out to the hospital. Interview with the Director of Nursing on January 14, 2025, at 3:03 p.m. revealed that someone came to her office and indicated that Resident 2 was being sent out to the hospital. They said that the family went to Registered Nurse 1 and told her that the resident was "a little off." So, she went back to see the resident. She indicated that she sat on the bed and spoke with the resident, and the resident did not look to be in any distress. She then told Registered Nurse 1 to go and do her assessment and then to notify the physician and the resident's family. She indicated that she went back to her office and had very little involvement after that.	F 0684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395592	A. BLDG: __00_____ B. WING: _____	01/15/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
HAIDA NURSING AND REHAB STATE LICENSE NUMBER: **340102**	**397 THIRD AVENUE EXTENSION HASTINGS, PA 16646**

(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 0684 SS=D	Continued from page 13 Interview with Licensed Practical Nurse 3 on January 14, 2025, at 3:15 p.m. revealed that he worked over from the night shift that night and he was waiting to do count with Registered Nurse 1 when someone came up to Registered Nurse 1 indicating that Resident 2 did seem like herself. Registered Nurse 1 asked me to go with her because she was relatively new to the facility and does not know all the residents. The resident thought she was in the emergency room. So, they returned to the nurses' station and Registered Nurse 4, who was the night shift supervisor, was still there, so she began helping Registered Nurse 1 with the transfer paperwork for the resident. He indicated that when he was leaving around 8:00 a.m. he was under the impression that they were sending the resident to the hospital. Interview with Registered Nurse 4 on January 14, 2025, at 3:28 p.m. revealed that she gave report to Registered Nurse 1 when she came in for the daylight shift. Then someone came up to Registered	F 0684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395592	A. BLDG: __00_____ B. WING: _____	01/15/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
HAIDA NURSING AND REHAB STATE LICENSE NUMBER: **340102**	**397 THIRD AVENUE EXTENSION HASTINGS, PA 16646**

(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 0684 SS=D	Continued from page 14 Nurse 1 and indicated that Resident 2 was incoherent and wanted her sent out to the hospital and that that person was going to call someone. Registered Nurse 1 then went back to assess the resident and when she came back, she was trying to get papers around to send her out to the hospital, so Registered Nurse 4 helped her. The Director of Nursing was there, and she went back to see the resident. When the Director of Nursing returned, she indicated that she thought the resident did not need to be sent out. 28 Pa. Code 211.12(d)(1)(5) Nursing Services.	F 0684		
F 0842 SS=D		F 0842		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395592	A. BLDG: __00_____ B. WING: _____	01/15/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
HAIDA NURSING AND REHAB STATE LICENSE NUMBER: **340102**	**397 THIRD AVENUE EXTENSION HASTINGS, PA 16646**

(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 0842 SS=D	Continued from page 15 483.20(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	1. Resident 2 no longer resides in the facility. 2. DON/Designee will review progress notes and 24-hour report daily to ensure complete documentation of resident's assessments, Physician notification, and Resident representative is completed in the medical record. 3. The Director of Nursing/Designee will educate Registered nurses on the importance of documenting complete assessments, Physician notification, orders received by the Physician, and updating of resident's representatives in the medical record. 4. The Director of Nursing/Designee will audit daily by reviewing progress notes and the 24-hour	Completion Date: **02/11/2025** Status: **APPROVED** Date: **01/30/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395592	A. BLDG: __00_____ B. WING: _____	01/15/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
HAIDA NURSING AND REHAB STATE LICENSE NUMBER: **340102**	**397 THIRD AVENUE EXTENSION HASTINGS, PA 16646**

(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 0842 SS=D	Continued from page 16 (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	report to ensure complete assessments, Physician notification, orders received by the Physician, and resident Representatives notification is documented in the medical record. This audit will be completed daily 5 times for two weeks, then three times a week times 2 weeks, then weekly times two weeks, then monthly times two months. Results of the audits will be reviewed at the Quality Assurance meetings until substantial compliance has been met. 5. The completion date will be 02/11/2025.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395592	A. BLDG: __00_____ B. WING: _____	01/15/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
HAIDA NURSING AND REHAB STATE LICENSE NUMBER: **340102**	**397 THIRD AVENUE EXTENSION HASTINGS, PA 16646**

(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 0842 SS=D	Continued from page 17 This REQUIREMENT is not met as evidenced by:	F 0842		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395592	A. BLDG: __00_____ B. WING: _____	01/15/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
HAIDA NURSING AND REHAB STATE LICENSE NUMBER: **340102**	**397 THIRD AVENUE EXTENSION HASTINGS, PA 16646**

(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 0842 SS=D	Continued from page 18 Based on review of facility policies and clinical records, as well as staff interviews, it was determined that the facility failed to ensure that clinical records were complete and accurately documented for one of seven residents reviewed (Resident 2). Findings Include: The facility's policy regarding charting and documentation, dated July 25, 2024, indicated that documentation in the medical record will be objective, complete, and accurate. A quarterly Minimum Data Set (MDS) assessment (a federally-mandated assessment of a resident's abilities and care needs) for Resident 2, dated November 20, 2024, revealed that the resident was understood, could understand others, and had Crohn's disease (a chronic inflammatory bowel disease that causes inflammation in the digestive tract), diabetes (a chronic disease that occurs when	F 0842		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395592	A. BLDG: __00_____ B. WING: _____	01/15/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
HAIDA NURSING AND REHAB STATE LICENSE NUMBER: **340102**	**397 THIRD AVENUE EXTENSION HASTINGS, PA 16646**

(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 0842 SS=D	Continued from page 19 the body can not produce or use insulin properly, resulting in high blood sugar levels), and hemiplegia (a neurological condition that causes paralysis or weakness on one side of the body). The resident's clinical record revealed that Resident Family Member 2 (son) and Resident Family Member 3 (daughter-in-law) were the resident's emergency contacts and were interested family members. A nursing note for Resident 2, completed by Registered Nurse 1, dated January 6, 2025, at 8:00 a.m., revealed that Resident Family Member 3 was at the nurses' station stating, "I want her sent out." Upon assessment, the resident was awake, alert, and oriented to self. She stated that she was "in the emergency room." Her skin was warm and dry, cheeks "ruddy." She was afebrile (no increased temperature), and her vital signs were stable. Physician 2 was made aware, and no new orders were received. A statement completed by Registered Nurse 1, dated January 9, 2025, revealed that on January 6,	F 0842		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395592	A. BLDG: 00 B. WING:	01/15/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
HAIDA NURSING AND REHAB STATE LICENSE NUMBER: **340102**	**397 THIRD AVENUE EXTENSION HASTINGS, PA 16646**

(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 0842 SS=D	Continued from page 20 2025, at approximately 8:00 a.m. she entered Resident 2's room due to Resident Family Member 3 stating she felt that the resident was "having a stroke." The resident was lying in bed with no visible signs of distress. The resident was awake, alert, her smile was symmetrical, her tongue was mid-line, her hand grasps and pedal pulses equal and strong. Her vital signs were stable. She then spoke with Resident Family Member 2 when he called in, informed him of the assessment, and that if there was something they can treat there, they would do so. A statement completed by the Director of Nursing, dated January 9, 2025, revealed that approximately 8:30 a.m. on January 6, 2025, she was notified that the family was questioning if Resident 2 should be transferred to the hospital. She walked back to the resident's room to visualize her status. At that time, she was alert and oriented and talking and did not appear to be in any distress. The Director of Nursing conferred with Registered Nurse 1, who stated that she assessed the resident, and she also	F 0842		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395592	A. BLDG: __00_____ B. WING: _____	01/15/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
HAIDA NURSING AND REHAB STATE LICENSE NUMBER: **340102**	**397 THIRD AVENUE EXTENSION HASTINGS, PA 16646**

(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 0842 SS=D	Continued from page 21 did not see that the resident was in any distress. Interview with Physician 2 on January 14, 2025, at 1:42 p.m. revealed that when he received a text regarding Resident 2, he gave an order to send the resident out to the hospital at that time. He then received a text that said the resident was not going out to the hospital. He indicated that he was not aware of what changed as to why they did not send her out to the hospital at that time. There was no documented evidence that the assessments of Resident 2 by Registered Nurse 1 and the Director of Nursing, or the physician's orders to send the resident to the hospital were in the resident's clinical record. Interview with the Regional Director of Clinical Services 5 on January 14, 2025, at 2:05 p.m. revealed that they spoke with Registered Nurse 1 regarding the morning of January 6, 2025, as well as had her write a statement after a family member voiced a grievance. Registered Nurse 1's statement	F 0842		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395592	A. BLDG: __00_____ B. WING: _____	01/15/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
HAIDA NURSING AND REHAB STATE LICENSE NUMBER: **340102**	**397 THIRD AVENUE EXTENSION HASTINGS, PA 16646**

(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 0842 SS=D	Continued from page 22 indicated that she was assessing for a stroke and she was asked why that part of the assessment was not documented in the medical record. Registered Nurse 1 told them that she forgot to go back into the electronic medical record to update her note. She also confirmed that the physician's order for Resident 2 to be sent out to the hospital was not in the resident's clinical record and that Registered Nurse 1's assessments from her statement were not in the clinical record. Interview with Registered Nurse 1 on January 14, 2025, at 2:30 p.m. she indicated that she went back throughout her shift to re-evaluate the resident on January 6, 2025. She confirmed that she did not put the physician's orders for her to be transferred out to the hospital or her re-evaluation assessments throughout her shift in the electronic medical record for Resident 2, as well as go back in to update her note from January 6, 2025, with her assessment finding as stated in her statement from January 9, 2025.	F 0842		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395592	A. BLDG: __00_____ B. WING: _____	01/15/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
HAIDA NURSING AND REHAB STATE LICENSE NUMBER: **340102**	**397 THIRD AVENUE EXTENSION HASTINGS, PA 16646**

(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 0842 SS=D	Continued from page 23 28 Pa. Code 211.5(f) Clinical Records.	F 0842		

Certified End Page

HAIDA NURSING AND REHAB

STATE LICENSE NUMBER: 340102

SURVEY EXIT DATE: 01/15/2025

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

Jeanne Parisi
Deputy Secretary for Quality Assurance

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

Pennsylvania
Department of Health

THIS IS A CERTIFICATION PAGE

PLEASE DO NOT DETACH

THIS PAGE IS NOW PART OF THIS SURVEY