STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395605	A. BLDG: 00 B. WING:	01/30/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
ST. BARNABAS NURSING HOME STATE LICENSE NUMBER: **710302**	**5827 MERIDIAN ROAD** **GIBSONIA, PA 15044**

(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, State Licensure, and Civil Rights Compliance Survey completed on January 30, 2025, it was determined that St. Barnabas Nursing Home 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 0623 SS=E		F 0623		

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 0623 SS=E	Continued from page 1 483.15(c)(3)-(6)(8) Notice Requirements Before Transfer/Discharge §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)	F 0623	Assuming for the sake of this discussion, the validity of the deficiencies noted in the Department of Health's Statement of Deficiencies Report to St. Barnabas Nursing Home, Inc. for the Survey ending January 30, 2025, which St. Barnabas does not admit, we offer the following Plan of Correction. Nothing contained in the Plan of Correction shall/should be deemed an admission, either expressed or implied, on the part of St. Barnabas Nursing Home, Inc. as to the validity of the deficiencies noted in the report. The monthly letter on transfers/discharges has been corrected to be mailed to the correct location of the State Office of Long-Term Care Ombudsman. The letter will continue to be completed monthly and as needed and submitted per email, at the request of the State Office of Long-Term Care Ombudsman as opposed to submitting to the Allegheny County Office of Long-Term Care Ombudsman. The	Completion Date: **01/29/2025** Status: **APPROVED** Date: **02/20/2025**

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F 0623 SS=E	Continued from page 2 (1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and	F 0623	transfers/discharges letter for December 2024 and January 2025 have already been submitted to the State Office of Long-Term Care Ombudsman via email. Education provided to administrative staff by the Administrator. A Quality Assurance Program will be implemented to ensure the letter is sent to the correct location and will be monitored on a monthly basis for the next 3 months and reported to the QAPI Committee.	

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F 0623 SS=E	Continued from page 3 (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(k). This REQUIREMENT is not met as evidenced by:	F 0623		

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F 0623 SS=E	Continued from page 4 Based on clinical record review and staff interviews, it was determined that the facility failed to provide a transfer notice to a representative of the Office of the Long-Term Care Ombudsman Division for four of four residents (Residents R1, R18, R27, and R32). Findings include: Review of the clinical record revealed Resident R1 was admitted to the facility on 1/10/23. Review of Resident R1's Minimum Data Set (MDS - a periodic assessment of care needs) dated 11/24/24, indicated diagnoses of hemiplegia, affecting right side (medical condition that causes paralysis or weakness on one side of the body), diabetes mellitus, and hypertension. Review of Resident R1's clinical record revealed that the resident was transferred to the hospital on 8/27/24.	F 0623		

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F 0623 SS=E	Continued from page 5 Review of Resident R1's clinical record, the facility failed to include documented evidence that the facility provided a written transfer notification to the Office of Long-Term Care Ombudsman for the hospitalization on 8/27/24. Review of the clinical record revealed Resident R18 was admitted to the facility on 8/22/24. Review of Resident R18's MDS dated 1/19/24, indicated diagnoses of high blood pressure, anemia (too little iron in the blood), and retention of urine. Review of Resident R18's clinical record revealed that the resident was transferred to the hospital on 10/8/24. Review of Resident R18's clinical record, the facility failed to include documented evidence that the facility provided a written transfer notification to the Office of Long-Term Care Ombudsman for the hospitalization on 10/8/24.	F 0623		

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F 0623 SS=E	Continued from page 6 Review of the clinical record revealed Resident R27 was admitted to the facility on 9/16/24. Review of Resident R27's MDS dated 11/24/24, indicated diagnoses of congestive heart failure, respiratory failure with hypoxia and diabetes mellitus. Review of Resident R27's clinical record revealed that the resident was transferred to the hospital on 9/1/24. Review of Resident R27's clinical record, the facility failed to include documented evidence that the facility provided a written transfer notification to the Office of Long-Term Care Ombudsman for the hospitalization on 9/1/24. Review of the clinical record revealed Resident R32 was admitted to the facility on 1/7/25. Review of Resident R32's MDS dated 1/1/4/25, indicated diagnoses of high blood pressure,	F 0623		

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F 0623 SS=E	Continued from page 7 hyponatremia (too little sodium in the blood), and respiratory failure (a condition where the lungs cannot get enough oxygen into the blood). Review of Resident R32's clinical record revealed that the resident was transferred to the hospital on 1/16/25. Review of Resident R32's clinical record, the facility failed to include documented evidence that the facility provided a written transfer notification to the Office of Long-Term Care Ombudsman for the hospitalization on 1/16/25. During an interview on 1/29/25, at 10:30 a.m. Secretary Employee E3 confirmed that the facility failed to provide a transfer notice to a representative of the Office of the Long-Term Care Ombudsman Division for four of four residents as required. 28 Pa. Code 201.29 (a)(c.3)(2) Resident rights.	F 0623		

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F 0684 SS=D		F 0684		

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F 0684 SS=D	Continued from page 9 483.25 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	Resident 23 medications arrived from pharmacy and administered per orders. All residents' medication cards were evaluated to ensure medications are available. Nursing staff will be educated by the Director of Nursing or designee on ensuring that medications are available and the need to reorder is completed timely, as well as physician notified when medication are not given. Night shift will check medication carts for need to reorder medication before quantity is low. Charge nurse will check daily if meds are not available or not received, with unit nurse, to ensure they are ordered and MD aware. Audits will be completed that nurses reorder medications timely and MD notification for medication not received. The Director of Nursing or a designee will audit for medications that quantity is sufficient weekly for a month. Bi-weekly for a month and monthly thereafter. All results will be reviewed at QAPI. Resident 36 MD aware of weight	Completion Date: **03/07/2025** Status: **APPROVED** Date: **02/20/2025**

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F 0684 SS=D	Continued from page 10	F 0684	loss. Dietician restarted on 11-6-2024. Dietician reviewing all weights and notifying physician timely. All residents reviewed for weight loss and MD updated as indicated. Changes in orders implemented on recommendation. Dietician educating nursing on notifying MD on weight loss and changing orders for tube feeding on recommendation. QAPI for Weight loss MD notification and change in orders will be done by the dietician or designee, weekly for one month, bi-weekly for one month and monthly thereafter. All results will be reviewed with the QAPI committee.	

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F 0684 SS=D	Continued from page 11 Based on review of clinical record review and staff interviews it was determined that the facility failed to follow physician orders for one of seven residents (Resident R23) and failed to provide appropriate treatment and care by failing to ensure timely notification to the physician of significant weight loss and failing to implement physician orders in a timely manner for one of seven residents (Resident R36). Findings include: Review of facility policy "Physician Notification" dated 5/23/24, indicated attending physicians will be notified of changes in resident conditions, incidents involving resident injury, or have the potential for needing physician interventions. Review of facility policy "Weight Loss Prevention" dated 5/23/24, indicated to update MD (physician) and obtain orders as needed. The Resident Assessment Instrument (RAI) User's Manual, which gives instructions for completing	F 0684		

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F 0684 SS=D	Continued from page 12 Minimum Data Set (MDS) assessments (mandated assessments of a resident's abilities and care needs), dated October 2024, indicated the following instructions: - Section K0300: significant weight loss is defined as 5% weight loss or more in 30 days or 10% weight loss or more in 180 days GUIDANCE §483.25(g) Significant weight loss is defined as: 5% or greater in one month 7.5% or greater in three months 10% or greater in six months Review of the clinical record indicated that Resident R23 was admitted to the facility on 5/22/24, with diagnosis that included congestive heart failure, cerebral palsy (group of disorders that affect movement, muscle tone, and posture due to damage or abnormal development of the brain during or shortly after birth) and asthma.	F 0684		

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F 0684 SS=D	Continued from page 13 Review of Resident R23's physician orders dated 7/19/24, indicated that Resident R23 was ordered Empagliflozin Oral Tablet 10 MG (milligrams) 1 tablet by mouth. Review of Resident R23's MAR (medical administration record), the following was not administered: Empagliflozin 1/20/25, 1/19/25, 12/21/24, 12/7/24, 12/6/24. Review of Resident R23's clinical nurse notes indicated medications "awaiting med to be delivered from pharmacy" and resident R23 did not receive on 1/20/25, 1/19/25, 12/21/24, 12/7/24, 12/6/24. During an interview on 1/30/25, at 11:00 a.m. the Director of Nursing confirmed that resident did not receive the medication on the above days and the physician was not notified. Review of the clinical record revealed Resident R36 was admitted to the facility on 10/2/20.	F 0684		

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F 0684 SS=D	Continued from page 14 Review of Resident R36's Minimum Data Set (MDS - a periodic assessment of care needs) dated 1/12/25, indicated diagnoses of anemia (too little iron in the body), Alzheimer's Disease (a progressive disease that destroys memory and other important mental functions), and hyperlipidemia (high levels of fat in the blood). Review of Resident R36's MDS dated 10/20/24, Section K - Swallowing/Nutritional Status, Question K0300 Weight Loss was coded "2" indicating a loss of 5% or more in the last month or loss of 10% or more in last 6 months and not on a physician-prescribed weight-loss regimen. Review of Resident R36's "Weight Summary" revealed the following documented weights: - 9/2/24: 119.5 lbs (pounds) - 9/30/24 = 108.6 lbs, a loss of 9.12% in one month - 10/1/24 = 108.6 lbs - 10/14/24 = 108 lbs	F 0684		

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F 0684 SS=D	Continued from page 15 - 11/3/24 = 107.8 lbs - 11/12/24 = 105.9 lbs - 11/25/24 = 107.5 lbs - 12/2/24 = 105.1 lbs - 12/9/24 = 101.5 lbs, a loss of 15% in three months Review of Resident R36's clinical record indicated that the physician was not made aware of Resident R36's 9.12% weight loss until 11/1/24. Review of "Daily Progress" note dated 11/1/24, indicated Resident R36 experiences frequent increased stomach residual necessitating need to hold/stop feeding and had significant weight loss noted in 30-day period 119.5 to 108.6. The physician documented, "Weight loss noted - needs full nutritional assessment and perhaps a change in substrate (tube feeding formula)." Review of a physician order dated 7/31/24, and discontinued on 9/21/24, indicated to administer Osmolite 1.5 (a type of tube feeding formula) via	F 0684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395605	A. BLDG: __00_____ B. WING: _____	01/30/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
ST. BARNABAS NURSING HOME STATE LICENSE NUMBER: **710302**	**5827 MERIDIAN ROAD GIBSONIA, PA 15044**

(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 16 G-tube (a surgically inserted tube into the stomach to provide nutrition) at 45cc/hour (milliliters per hour); hold tube feeding daily from 12 a.m. to 4 a.m. Review of a physician order dated 9/21/24, and discontinued on 12/13/24, indicated to administer Osmolite 1.5 via G-tube at 40cc/hour; hold tube feeding daily from 12 a.m. to 4 a.m. Review of the above order indicates this is a decrease in amount of formula to be administered. Review of Resident R36's clinical record failed to include documentation to support the change in the tube feeding order. Review of a physician order dated 12/12/24, indicated to administer Nutren 2.0 (a type of tube feeding formula) via G-tube at 40cc/hour; hold tube feeding daily from 12 a.m. to 4 a.m. During an interview on 1/29/25, at 1:45 p.m. Licensed Practical Nurse Assessment Coordinator	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=D	Continued from page 17 (LPNAC) Employee E4 stated, "I caught the weight loss in October when I was filling out that portion of the MDS. Usually, the Registered Dietitian would be who catches weight loss and makes recommendations. I round with the physician and made him aware of the weight loss on November 1st and the physician gave a verbal order to change her tube feeding formula. It wasn't changed to a different formula until December 12th because we had to use up her current tube feeding supply, we can't return anything." During an interview on 1/29/25, at 1:45 p.m. LPNAC Employee E4 confirmed that the facility failed to provide appropriate treatment and care by failing to ensure timely notification to the physician of significant weight loss and failing to implement physician orders in a timely manner as required. 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	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=D	Continued from page 18 services.	F 0684		
F 0692 SS=E	483.25(g)(1)-(3) Nutrition/Hydration Status Maintenance §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by:	F 0692	Resident 36 MD aware of the weight loss. Dietician restarted on 11-6-2024. Dietician reviewing all weights and notifying physician timely. All residents reviewed for weight loss and MD updated as indicated. Resident 29 and Resident 49 nutritional assessments completed. All residents verified for having a current nutritional assessment. Dietician will monitor all current residents and any new admissions to ensure they have an assessment. Dietician educating nursing on need for nutritional assessments and addressing weight loss timely. QAPI will be initiated on timely notification of physician on weight loss and nutritional assessments completed on new admissions, weekly for one month, bi-weekly for one month and monthly thereafter. All results for QAPI will be reported to the QA committee.	Completion Date: **03/07/2025** Status: **APPROVED** Date: **02/20/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0692 SS=E	Continued from page 19 Based on review of facility policies, clinical records, and staff interviews, it was determined that the facility failed to make certain that weight loss was identified and addressed in a timely manner for one of three residents (Resident R36) and the facility failed to complete initial nutrition assessments for two to seven residents (Resident R29, R49). Findings include: Review of facility policy "Weight Loss Prevention" dated 5/23/24, indicated Dietitian or Dietitian Tech to evaluate and make recommendations as indicated. Update MD (physician) and obtain orders as needed. The Resident Assessment Instrument (RAI) User's Manual, which gives instructions for completing Minimum Data Set (MDS) assessments (mandated assessments of a resident's abilities and care needs), dated October 2024, indicated the following instructions: - Section K0300: significant weight loss is defined	F 0692		

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F 0692 SS=E	Continued from page 20 as 5% weight loss or more in 30 days or 10% weight loss or more in 180 days GUIDANCE §483.25(g) Significant weight loss is defined as: 5% or greater in one month 7.5% or greater in three months 10% or greater in six months Review of the clinical record revealed Resident R36 was admitted to the facility on 10/2/20. Review of Resident R36's Minimum Data Set (MDS - a periodic assessment of care needs) dated 1/12/25, indicated diagnoses of anemia (too little iron in the body), Alzheimer's Disease (a progressive disease that destroys memory and other important mental functions), and hyperlipidemia (high levels of fat in the blood). Review of Resident R36's MDS dated 10/20/24, Section K - Swallowing/Nutritional Status, Question	F 0692		

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F 0692 SS=E	Continued from page 21 K0300 Weight Loss was coded "2" indicating a loss of 5% or more in the last month or loss of 10% or more in last 6 months and not on a physician-prescribed weight-loss regimen. Review of a physician order dated 7/31/24, and discontinued on 9/21/24, indicated to administer Osmolite 1.5 (a type of tube feeding formula) via G-tube (a surgically inserted tube into the stomach to provide nutrition) at 45cc/hour (milliliters per hour); hold tube feeding daily from 12 a.m. to 4 a.m. Review of a physician order dated 9/21/24, and discontinued on 12/13/24, indicated to administer Osmolite 1.5 via G-tube at 40cc/hour; hold tube feeding daily from 12 a.m. to 4 a.m. Review of the above order indicates this is a decrease in amount of formula to be administered. Review of Resident R36's clinical record failed to include documentation to support the change in the tube feeding order.	F 0692		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0692 SS=E	Continued from page 22 Review of a physician order dated 12/12/24, indicated to administer Nutren 2.0 (a type of tube feeding formula) via G-tube at 40cc/hour; hold tube feeding daily from 12 a.m. to 4 a.m. Review of a "Weight Change Note" dated 8/13/24, completed by Registered Dietitian (RD) Employee E1 stated, "Review of monthly weight status. Per weight 8/1 120# (pounds), resident with trigger for significant weight loss for 6 months (133.5#, -10.1%). Weight stable past 3 months 116-121#. Continue current TF (tube feeding) as ordered/resident tolerates. Continue to monitor weight status for significant change." Review of Resident R36's "Weight Summary" revealed the following documented weights: - 9/2/24: 119.5 lbs (pounds) - 9/30/24 = 108.6 lbs, a loss of 9.12% in one month - 10/1/24 = 108.6 lbs - 10/14/24 = 108 lbs	F 0692		

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F 0692 SS=E	Continued from page 23 - 11/3/24 = 107.8 lbs - 11/12/24 = 105.9 lbs - 11/25/24 = 107.5 lbs - 12/2/24 = 105.1 lbs - 12/9/24 = 101.5 lbs, a loss of 15% in three months Review of Resident R36's clinical record failed to include documentation that indicated the resident was assessed by the Registered Dietitian in September 2024, October 2024, November 2024, and December 2024. The review of the clinical record failed to reveal any documentation regarding the above weight changes or any nutritional recommendations. During an interview on 1/29/25, at 9:32 a.m. RD Employee E1 stated, "I was not employed at the facility between 8/20/24 and 11/6/24. I can't speak exactly to Resident R36's weight loss in September. I was notified through email communication at the beginning of November. My recommendation was to increase her tube feeding rate, but her husband	F 0692		

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F 0692 SS=E	Continued from page 24 dictates most of her care and had no desire to increase the tube feeding rate." When asked if it is documented in Resident R36's clinical record that her husband refused to have nutritional recommendations implemented, RD Employee E1 stated, "Nobody would dare put that in." Review of the clinical record revealed Resident R29 was admitted to the facility on 10/15/24. Review of Resident R29's Minimum Data Set (MDS - a periodic assessment of care needs) dated 1/12/25, indicated diagnoses of fracture of right femur, orthopedic aftercare and atrial fibrillation (common heart rhythm disorder where the upper chambers of the heart (atria) beat irregularly and rapidly). Review of Resident R29's clinical record failed to include documentation that indicated the resident was assessed by the Registered Dietitian in October 2024, November 2024, and December 2024.	F 0692		

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F 0692 SS=E	Continued from page 25 Review of the clinical record revealed Resident R49 was admitted to the facility on 10/29/24. Review of Resident R49's Minimum Data Set (MDS - a periodic assessment of care needs) dated 11/10/24, indicated diagnoses of asthma, nonrheumatic aortic stenosis (a narrowing of the aortic valve that occurs when it doesn't open or close properly) and syncope (a sudden and brief loss of consciousness that is caused by a temporary decrease in blood flow to the brain). Review of Resident R49's clinical record failed to include documentation that indicated the resident was assessed by the Registered Dietitian in October 2024, November 2024, and December 2024. During an interview on 1/29/25, at 9:44 a.m. RD Employee E1 confirmed that the facility failed to make certain that weight loss was identified and addressed in a timely manner for Resident R36 and the facility failed to assess two residents on admission as required (Resident R29, and R49).	F 0692		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0692 SS=E	Continued from page 26 28 Pa. Code: 201.18(b)(1)(e)(1) Management. 28 Pa. Code: 211.12(d)(1)(3)(5) Nursing services.	F 0692		
F 0693 SS=D	483.25(g)(4)(5) Tube Feeding Mgmt/Restore Eating Skills §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by:	F 0693	Resident R36 is on the ordered tube feeding. There are no other tube feed residents presently in the building. Education being completed to nursing by the dietician or designee on orders for tube feedings being updated when recommended and ordered as well as weight loss monitored and nutritional assessment completed with weight loss. Education will include changing the feeding immediately when ordered and available. A QAPI will be completed to ensure weight loss and nutritional assessments completed by the dietician or designee. Weekly for one month, bi-weekly for one month and weekly thereafter. All results will be reported at to the QA committee.	Completion Date: **03/07/2025** Status: **APPROVED** Date: **02/20/2025**

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F 0693 SS=D	Continued from page 27	F 0693		

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F 0693 SS=D	Continued from page 28 Based on review of facility policy, clinical record review, and staff interview, it was determined that the facility failed to ensure that a resident with an enteral feeding tube (a tube inserted in the stomach through the abdomen) received appropriate treatment and services for one of four residents (Resident R36). Findings include: Review of facility policy "Enteral Therapy" dated 5/23/24, indicated the dietitian will assess the resident's nutritional needs and provide consultation to the MD (physician) as indicated. Review of facility policy "Weight Loss Prevention" dated 5/23/24, indicated Dietitian or Dietitian Tech to evaluate and make recommendations as indicated. Update MD (physician) and obtain orders as needed. The Resident Assessment Instrument (RAI) User's Manual, which gives instructions for completing	F 0693		

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F 0693 SS=D	Continued from page 29 Minimum Data Set (MDS) assessments (mandated assessments of a resident's abilities and care needs), dated October 2024, indicated the following instructions: - Section K0300: significant weight loss is defined as 5% weight loss or more in 30 days or 10% weight loss or more in 180 days GUIDANCE §483.25(g) Significant weight loss is defined as: 5% or greater in one month 7.5% or greater in three months 10% or greater in six months Review of the clinical record revealed Resident R36 was admitted to the facility on 10/2/20. Review of Resident R36's Minimum Data Set (MDS - a periodic assessment of care needs) dated 1/12/25, indicated diagnoses of anemia (too little iron in the body), Alzheimer's Disease (a progressive disease that destroys memory and other	F 0693		

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F 0693 SS=D	Continued from page 30 important mental functions), and hyperlipidemia (high levels of fat in the blood). Review of Resident R36's MDS dated 10/20/24, Section K - Swallowing/Nutritional Status, Question K0300 Weight Loss was coded "2" indicating a loss of 5% or more in the last month or loss of 10% or more in last 6 months and not on a physician-prescribed weight-loss regimen. Review of a physician order dated 7/31/24, and discontinued on 9/21/24, indicated to administer Osmolite 1.5 (a type of tube feeding formula) via G-tube (a surgically inserted tube into the stomach to provide nutrition) at 45 cc/hour (milliliters per hour); hold tube feeding daily from 12 a.m. to 4 a.m. Review of a physician order dated 9/21/24, and discontinued on 12/13/24, indicated to administer Osmolite 1.5 via G-tube at 40cc/hour; hold tube feeding daily from 12 a.m. to 4 a.m. Review of the above order indicates this is a	F 0693		

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F 0693 SS=D	Continued from page 31 decrease in amount of formula to be administered. Review of Resident R36's clinical record failed to include documentation to support the change in the tube feeding order. Review of a physician order dated 12/12/24, indicated to administer Nutren 2.0 (a type of tube feeding formula) via G-tube at 40cc/hour; hold tube feeding daily from 12 a.m. to 4 a.m. Review of a "Weight Change Note" dated 8/13/24, completed by Registered Dietitian (RD) Employee E1 stated, "Review of monthly weight status. Per weight 8/1 120# (pounds), resident with trigger for significant weight loss for 6 months (133.5#, -10.1%). Weight stable past 3 months 116-121#. Continue current TF (tube feeding) as ordered/resident tolerates. Continue to monitor weight status for significant change." Review of Resident R36's "Weight Summary" revealed the following documented weights:	F 0693		

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	395605	A. BLDG: 00 B. WING:	01/30/2025

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F 0693 SS=D	Continued from page 32 - 9/2/24: 119.5 lbs (pounds) - 9/30/24 = 108.6 lbs, a loss of 9.12% in one month - 10/1/24 = 108.6 lbs - 10/14/24 = 108 lbs - 11/3/24 = 107.8 lbs - 11/12/24 = 105.9 lbs - 11/25/24 = 107.5 lbs - 12/2/24 = 105.1 lbs - 12/9/24 = 101.5 lbs, a loss of 15% in three months Review of Resident R36's clinical record failed to include documentation that indicated the resident was assessed by the Registered Dietitian in September 2024, October 2024, November 2024, and December 2024. The review of the clinical record failed to reveal any documentation regarding the above weight changes or any nutritional recommendations. During an interview on 1/29/25, at 9:32 a.m. RD Employee E1 stated, "I was not employed at the	F 0693		

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F 0693 SS=D	Continued from page 33 facility between 8/20/24 and 11/6/24. I can't speak exactly to Resident R36's weight loss in September. I was notified through email communication at the beginning of November. My recommendation was to increase her tube feeding rate, but her husband dictates most of her care and had no desire to increase the tube feeding rate." When asked if it is documented in Resident R36's clinical record that her husband refused to have nutritional recommendations implemented, RD Employee E1 stated, "Nobody would dare put that in." Review of Resident R36's clinical record indicated that the physician was not made aware of Resident R36's 9.12% weight loss until 11/1/24. Review of "Daily Progress" note dated 11/1/24, indicated Resident R36 experiences frequent increased stomach residual necessitating need to hold/stop feeding and had significant weight loss noted in 30-day period 119.5 to 108.6. The physician documented, "Weight loss noted - needs full nutritional assessment and perhaps a change in	F 0693		

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F 0693 SS=D	Continued from page 34 substrate (tube feeding formula)." During an interview on 1/29/25, at 1:45 p.m. Licensed Practical Nurse Assessment Coordinator (LPNAC) Employee E4 stated, "I caught the weight loss in October when I was filling out that portion of the MDS. Usually, the Registered Dietitian would be who catches weight loss and makes recommendations. I round with the physician and made him aware of the weight loss on November 1st and the physician gave a verbal order to change her tube feeding formula. It wasn't changed to a different formula until December 12th because we had to use up her current tube feeding supply, we can't return anything." During an interview on 1/29/25, at 1:45 p.m. LPNAC Employee E4 confirmed that the facility failed to ensure that a resident with an enteral feeding tube received appropriate treatment and services as required. 28 Pa. Code: 201.18(b)(1) Management.	F 0693		

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F 0693 SS=D	Continued from page 35 28 Pa. Code: 211.10(c) Resident care policies. 28 Pa. Code: 211.12(d)(1) Nursing services.	F 0693		
F 0695 SS=D		F 0695		

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F 0695 SS=D	Continued from page 36 483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by:	F 0695	Resident 32 oxygen order updated for the liter flow of oxygen, that was needed. All resident records evaluated to ensure that the physician order matched the delivery of liter flow. Staff re-educated that oxygen delivery will have an order and be in the care plan. Staff will also verify oxygen order to the oxygen concentrator each shift by the Director of Nursing or designee. Audits to be completed by the director of nursing or designee to ensure that the oxygen flow that the resident is receiving matches the physician orders. Audits completed weekly for one month, bi-weekly for one month and monthly thereafter. All results will be reviewed with the QAPI committee. Resident 36 nebulizer tubing had been changed 1/24/25, per our normal procedure of changing on Thursday, night shift. Order written to change tubing/aerosolizer weekly. All residents' nebulizer tubing checked and verified MD order for changing the tubing weekly and	Completion Date: **03/07/2025** Status: **APPROVED** Date: **02/20/2025**

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F 0695 SS=D	Continued from page 37	F 0695	noted in care plan. Staff education by the Director of nursing or designee completed on policy to add orders for the nebulizer tubing to be changed weekly for anyone ordered a nebulizer and anyone admitted with an order for nebulizer treatment. Change of tubing also to be noted in the care plan. QAPI will be done to ensure an order for nebulizer tubing changes is written for patients with a nebulizer. The director of Nursing or designee will audit residents with nebulizer treatments to ensure there is an order in place of for changing the tubing weekly. Audits will be completed weekly for one month, bi-weekly for one month and monthly thereafter. All results will be reviewed at by the QA committee.	

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F 0695 SS=D	Continued from page 38 Based on observations, staff interviews, and clinical record review, it was determined that the facility failed to provide appropriate respiratory care for two of four residents (Residents R32 and R36). Findings include: Review of the clinical record revealed Resident R32 was admitted to the facility on 1/7/25. Review of Resident R32's Minimum Data Set (MDS - a periodic assessment of care needs) dated 1/1/4/25, indicated diagnoses of high blood pressure, hyponatremia (too little sodium in the blood), and respiratory failure (a condition where the lungs cannot get enough oxygen into the blood). Review of a physician order dated 1/21/25, indicated to provide oxygen at 1 - 2 liters per minute (LPM) via nasal cannula (a lightweight tube that delivers oxygen into the nostrils) continuously. During an observation on 1/27/25, at 11:57 a.m.	F 0695		

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F 0695 SS=D	Continued from page 39 Resident R32 was observed receiving oxygen at 3 LPM via nasal cannula. During an observation on 1/28/25, at 8:57 a.m. Resident R32 was observed receiving oxygen at 3 LPM via nasal cannula. During an observation on 1/29/25, at 10:08 a.m. Resident R32 was observed receiving oxygen at 3 LPM via nasal cannula. During this observation, Registered Nurse (RN) Employee E2 confirmed that Resident R32 was receiving oxygen at 3 LPM via nasal cannula. During an interview on 1/29/25, at 10:08 a.m. RN Employee E2 confirmed that the facility failed to provide appropriate respiratory care for Resident R32. Review of the clinical record revealed Resident R36 was admitted to the facility on 10/2/20. Review of Resident R36's MDS dated 1/12/25,	F 0695		

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F 0695 SS=D	Continued from page 40 indicated diagnoses of anemia (too little iron in the body), Alzheimer's Disease (a progressive disease that destroys memory and other important mental functions), and hyperlipidemia (high levels of fat in the blood). Review of a physician order dated 10/5/24, indicated to administer Ipratropium-Albuterol 0.5-2.5 mg/mL (milligrams per milliliter) inhale orally every 4 hours as needed for congestion. Review of Resident R36's January Medication Administration Record indicated the resident received Ipratropium-Albuterol on 1/4/25, 1/12/25, 1/13/25, 1/17/25, 1/18/25, 1/19/25, 1/20/25, 1/24/25, and 1/25/25. During an observation on 1/27/25, at 9:50 a.m. a nebulizer machine (a machine used to deliver aerosolized medications) was observed on Resident R36's bedside table with the attached tubing and aerosolized face mask in a bag in the drawer.	F 0695		

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F 0695 SS=D	Continued from page 41 Review of Resident R36's physician orders on 1/29/25, failed to include an order to change the nebulizer tubing and aerosolized face mask. Review of Resident R36's care plan on 1/29/25, failed to include goals and interventions related to the maintenance of equipment for respiratory care and failed to include interventions for procedures to follow in the event of an adverse reaction to respiratory treatments. During an interview on 1/29/25, at 10:10 a.m. Registered Nurse (RN) Employee E2 stated, "I don't think there is an order to change the nebulizer tubing, I just know they do it at night on Thursday or Fridays." During an interview on 1/29/25, at 11:16 a.m. the Director of Nursing (DON) stated, "Nebulizer tubing is changed Thursday into Friday on the 11 p.m. to 7 a.m. shift, it's changed with the oxygen tubing, that's just how we do it." When asked how would a new employee or agency employee know	F 0695		

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F 0695 SS=D	Continued from page 42 when to change the nebulizer tubing, the DON stated, "It's part of orientation and onboarding, it would be discussed then." During this interview, the DON confirmed that Resident R36 did not have a physician order to change nebulizer tubing and did not have a care plan developed for the administration of aerosolized medications. During an interview on 1/30/25, at 10:01 a.m. the DON was asked to provide the facility's policies and procedures for respiratory care and aerosolized medication therapy. During an interview on 1/30/25, at 10:54 a.m. the DON stated that the facility does not have policies related to respiratory care and aerosolized medication therapy. During an interview on 1/30/25, at 10:54 a.m. the DON confirmed that the facility failed to provide appropriate respiratory care for Resident R36. 28 Pa. Code: 201.14(a) Responsibility of licensee.	F 0695		

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F 0695 SS=D	Continued from page 43 28 Pa. Code: 211.10(c)(d) Resident care policies. 28 Pa. Code: 211.11 (a)(c)(d) Resident care plan. 28 Pa. Code 211.12(d)(1)(2)(3)(5) Nursing services.	F 0695		
F 0760 SS=D		F 0760		

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F 0760 SS=D	Continued from page 44 483.45(f)(2) Residents are Free of Significant Med Errors The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by:	F 0760	Resident 50 medications arrived from pharmacy and administered per orders. All residents' medication cards were evaluated to ensure medications are available. Nursing staff will be educated by the Director of Nursing or designee on ensuring that medications are available and the need to reorder is completed timely, as well as physician notified when medication are not given. Night shift will check medication carts for need to reorder medication before quantity is low. Charge nurse will check daily if meds are not available or not received, with unit nurse, to ensure they are ordered and MD aware. Audits will be completed that nurses reorder medications timely and MD notification for medication not received. The Director of Nursing or a designee will audit for medications that quantity is sufficient weekly for a month. Bi-weekly for a month and monthly thereafter. All results will be reviewed at QAPI.	Completion Date: **03/07/2025** Status: **APPROVED** Date: **02/20/2025**

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F 0760 SS=D	Continued from page 45 Based on review of facility policy, clinical record, and staff interview, it was determined that the facility failed to make certain significant medications are administered as ordered by the physician for one of three residents (Resident R50). Findings include: Review of the facility policy "Medication Administration) dated 5/23/24 indicated medications and biologicals shall be administered by the same licensed nurse who prepared the dose for administration and will give as soon as possible after being prepared. Review of the clinical record indicated that Resident R50 was admitted to the facility on 11/22/24, with diagnoses which included atrial fibrillation (common heart rhythm disorder where the upper chambers of the heart (atria) beat irregularly and rapidly), hypertension and macular degeneration (common eye disease that damages the macula, the central part of the retina responsible for sharp, central	F 0760		

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F 0760 SS=D	Continued from page 46 vision). Review of Resident R50's physician orders dated 11/23/24 indicated Synthroid (to treat hypothyroidism) Oral Tablet 50 MCG (Levothyroxine Sodium) 1 tablet orally once a day. Review of Resident R50's Medication Administration Record (MAR) indicated that 12/29/24, 12/30/24, 1/21/25 and 1/27/25, staff had documented that the drug was unavailable and not given. Resident R50 had not received the medication for four days. During an interview on 1/30/25, at approximately 11:00 a.m., the Director of Nursing confirmed that the facility failed to make certain significant medications are administered as ordered by the physician. 28 Pa. Code: 201.14(a) Responsibility of licensee. 28Pa. Code:211.9(e)(f)(g)(h) Pharmacy services. 28 Pa. Code: 211.10(c) Resident care policies.	F 0760		

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F 0801 SS=D	483.60(a)(1)(2) Qualified Dietary Staff §483.60(a) Staffing The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71. This includes: §483.60(a)(1) A qualified dietitian or other clinically qualified nutrition professional either full-time, part-time, or on a consultant basis. A qualified dietitian or other clinically qualified nutrition professional is one who- (i) Holds a bachelor's or higher degree granted by a regionally accredited college or university in the United States (or an equivalent foreign degree) with completion of the academic requirements of a program in nutrition or dietetics accredited by an appropriate national accreditation organization recognized for this purpose. (ii) Has completed at least 900 hours of supervised dietetics practice under the supervision of a registered dietitian or nutrition professional. (iii) Is licensed or certified as a dietitian or nutrition professional by the State in which the services are performed. In a State that does not provide for licensure or certification, the individual will be deemed to have met this requirement if he or she is recognized as a "registered dietitian" by the Commission on Dietetic Registration or its successor organization, or meets the requirements of paragraphs (a)(1)(i) and (ii) of this section.	F 0801	Dietician was rehired and worked as a consultant from 11-6-2024 through present. On 2-17-2025 the dietician will again hold a part time position. If a qualified dietician is no longer employed, a contracted dietician will be hired either independently or through an agency until a new dietician is employed. All food service supervisors and current dietician have been educated on the requirements by the Administrator. The Administrator or designee will complete a monthly QAPI to ensure there is an appropriate dietician employed at the facility and results will be reported to the QAPI committee.	Completion Date: **03/07/2025** Status: **APPROVED** Date: **02/20/2025**

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 0801 SS=D	Continued from page 48 (iv) For dietitians hired or contracted with prior to November 28, 2016, meets these requirements no later than 5 years after November 28, 2016 or as required by state law. §483.60(a)(2) If a qualified dietitian or other clinically qualified nutrition professional is not employed full-time, the facility must designate a person to serve as the director of food and nutrition services. (i) The director of food and nutrition services must at a minimum meet one of the following qualifications- (A) A certified dietary manager; or (B) A certified food service manager; or (C) Has similar national certification for food service management and safety from a national certifying body; or D) Has an associate's or higher degree in food service management or in hospitality, if the course study includes food service or restaurant management, from an accredited institution of higher learning; or (E) Has 2 or more years of experience in the position of director of food and nutrition services in a nursing facility setting and has completed a course of study in food safety and management, by no later than October 1, 2023, that includes topics integral to managing dietary operations including, but not limited to, foodborne illness, sanitation procedures, and food purchasing/receiving; and (ii) In States that have established standards for food service managers or dietary managers, meets State requirements for food service managers or dietary managers, and (iii) Receives frequently scheduled consultations from a	F 0801		

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F 0801 SS=D	Continued from page 49 qualified dietitian or other clinically qualified nutrition professional. This REQUIREMENT is not met as evidenced by:	F 0801		

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F 0801 SS=D	Continued from page 50 Based on staff interviews it was determined that the facility failed to employ a qualified Registered Dietitian for one of twelve months (October 2024). Findings include: During an interview with Registered Dietitian Employee E1 revealed she was employed 6/29/21-8/20/24 and didn't start PRN again till 11/6/24. Interview with Nursing Home Administrator on 1/29/25 at 11:00 a.m. indicated the facility had a Registered Dietitian 9/5/24-10/4/24. During an interview on 1/29/25 at 9:00 a.m. the Nursing Home Administrator confirmed that the facility did not employ a qualified Registered Dietitian for one of twelve months as required. 28 Pa. Code 201. 18(e)(1)(6)Management. 28 Pa. Code 211. 6(c) Dietary service.	F 0801		

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F 0801 SS=D	Continued from page 51	F 0801		
F 0849 SS=D		F 0849		

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 0849 SS=D	Continued from page 52 483.70(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	Resident R32 diagnosis added for hospice care. All residents with hospice have been checked to ensure there is an admission diagnosis ordered with the start of hospice care. For all admissions to hospice, a diagnosis will be obtained from hospice and noted with the hospice order to admit to hospice, that clarifies why someone was admitted to hospice. The Director of nursing or designee will educate all the nursing staff that a diagnosis is needed in order for someone to be admitted to hospice and to verify the diagnosis is with the order for hospice services. The Director of Nursing or designee will initiate a QAPI to check that every new hospice admission has a diagnosis for admission to hospice. QAPI will be completed every week for 1 month, bi-weekly for one month and monthly thereafter. All results will be reviewed with the QA committee.	Completion Date: **02/26/2025** Status: **APPROVED** Date: **02/20/2025**

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F 0849 SS=D	Continued from page 53 (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		

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F 0849 SS=D	Continued from page 54 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 55 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 56 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 57 Based on a review of facility policy, resident clinical records, and staff interview, it was determined the facility failed to obtain a diagnosis for hospice services for one of four residents (Resident R32). Findings include: Review of facility policy "Hospice" dated 5/23/24, indicated care will be coordinated with hospice as indicated. Review of the clinical record revealed Resident R32 was admitted to the facility on 1/7/25. Review of Resident R32's Minimum Data Set (MDS - a periodic assessment of care needs) dated 1/1/4/25, indicated diagnoses of high blood pressure, hyponatremia (too little sodium in the blood), and respiratory failure (a condition where the lungs cannot get enough oxygen into the blood). Review of a physician order dated 1/22/25, indicated to admit Resident R32 to hospice, but did	F 0849		

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F 0849 SS=D	Continued from page 58 not include a diagnosis related to the need of hospice services. Review of Resident R32's care plan dated 1/22/25, revealed the resident has a terminal prognosis/receiving hospice care, but did not include a diagnosis related to the need for hospice services. During an interview on 1/20/25, at 9:15 a.m. the Director of Nursing confirmed that the facility failed to obtain a diagnosis for hospice services as required. 28 Pa. Code 211.2(a) Physician services. 28 Pa. Code 211.11(d) Resident care plan.	F 0849		
F 0880 SS=D		F 0880		

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F 0880 SS=D	Continued from page 59 483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported;	F 0880	Water lines were tested on January 29, 2025. Chlorine was at appropriate levels. Facility maintenance will enact a monthly water test on water lines to ensure correct levels of chorine are present. Water management manual updated to include water testing. All maintenance staff will be educated on the process and testing by the Director of Maintenance or designee. The Director of maintenance or designee will perform monthly testing to ensure proper levels of chlorine are present in the water supply lines. A QAPI will be started and verified by the Director of Maintenance or designee all results will be reported to the QA committee. Resident R36 plan of care was updated to reflect the enhanced barrier precautions that were in place for the resident and physician order obtained for Enhanced Barrier Precautions. All resident care plans and physician orders checked to ensure that enhanced barrier	Completion Date: **03/07/2025** Status: **APPROVED** Date: **02/20/2025**

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F 0880 SS=D	Continued from page 60 (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by:	F 0880	precautions present where necessary. Education provided by the Director of Nursing on updating the care plan and physician orders when enhanced barrier precautions are put into place. The director of nursing or designee will complete an audit that care plans and orders are updated with enhanced barrier precautions, weekly for one month, bi-weekly for one month and monthly thereafter. All results will be reported to the QA committee.	

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F 0880 SS=D	Continued from page 61	F 0880		

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F 0880 SS=D	Continued from page 62 Based on policy review, documentation review, review of Centers for Disease Control (CDC) guidelines for Legionella (bacteria that causes disease found in contaminated water) control, and staff interviews it was determined that the facility failed to maintain a comprehensive program for water management to monitor the potential development and spread of Legionella and failed to implement control measures for Legionella within the facility for eleven of twelve months (February 2024 through January 2025) and failed to implement transmission-based precautions for one of four residents (Resident R36). Findings include: Review of the facility policy "Legionella Prevention" dated 5/23/24, indicated the facility will utilize water management practices to reduce the risk of Legionella in the ice machines by cleaning quarterly, sanitizing, and checking monthly for cleanliness. The policy fails to mention how to prevent Legionella and other microbial growth throughout the facility.	F 0880		

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F 0880 SS=D	Continued from page 63 Core Elements of the Water Management Plan are: 1. Establish Water Management Plan team. 2. Describe Center's water system using text and flow diagram. 3. Risk assessment with control methods and corrective actions. 4. Monitoring control measures. 5. Corrective actions. 6. Verification and validation. 7. Documentation and communication. Review of Department of Health and Human services, Centers for Medicare and Medicaid services (CMS) memo, "Requirement to Reduce Legionella Risk in Healthcare Facility Water Systems to Prevent Cases and Outbreaks of Legionnaires' Disease (LD)" dated 7/6/18, revealed, "Facilities must develop and adhere to policies and procedures that inhibit microbial growth in building water systems that reduce the risk of growth and spread Legionella and other opportunistic pathogens in water. This policy memorandum applies to	F 0880		

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F 0880 SS=D	Continued from page 64 Hospitals, Critical Access Hospitals (CAHs) and Long-Term Care (LTC). However, this policy memorandum is also intended to provide general awareness for all healthcare organizations. Facilities must have water management plans and documentation that, at minimum, ensure each facility: -Conducts a facility risk assessment to identify where Legionella and other opportunistic waterborne pathogens (e.g. Pseudomonas, Acinetobacter, Nontuberculous Mycobacteria, Burkholderia, Stenotrophomonas, and fungi) could grow and spread in the facility water system. -Develops and implements a water management program that considers the ASHRAE (American Society of Heating, Refrigerating, and Air Conditioning Engineers) industry standard and the CDC toolkit. -Specifies testing protocols and acceptable ranges for control measures and document the results of testing and corrective actions taken when control limits are not maintained. -Maintains compliance with other applicable Federal, State and local requirements.	F 0880		

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F 0880 SS=D	Continued from page 65 Review of the ASHRAE guidance "Managing the Risk of Legionellosis Associated with Building Water Systems" dated December 2020, indicated the most commonly used supplemental disinfection methods are treatment with chlorine, chlorine-dioxide, copper-silver ions, and monochloramine." The guidance further indicated the recommended levels of residual chlorine are 0.50-3.00 ppm (part per million). Review of facility policy "Contact Precautions" dated 5/23/24, indicated contact precautions are intended to prevent transmission of infectious agents which are spread by direct or indirect contact with the resident or resident's environment. Review of facility policy "Enhanced Barrier Precautions" dated 5/23/24, indicated the facility will adhere to the CDC guideline recommendations for use of Enhanced Barrier Precautions (EBP) when providing care to residents identified as at risk for multi-drug resistant organisms (MDRO) or to those	F 0880		

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F 0880 SS=D	Continued from page 66 residents identified as having a MDRO infection. The CDC defines Enhanced Barrier Precautions as: an infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDROs) in nursing homes. EBP involve gown and gloves during high-contact resident care activities for residents known to be colonized or infected with MDRO as well as those at increased risk of MDRO acquisition (e.g., residents with wounds or indwelling medical devices). Review of the facility provided water management information failed to include specific testing protocols and acceptable ranges for control measures along with a description of the facility's water system using a flow diagram. Review of the Water Management Program Control Measures did not contain a log for Point of Use Disinfectant (the level of chlorine concentration in the water) indicated to measure and record hot water and cold water chlorine concentration as point	F 0880		

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F 0880 SS=D	Continued from page 67 of use, and to note that chlorine concentration below 0.5 ppm and above 4.0 ppm as outside the control limits. During an interview on 1/28/25, at approximately 11:30 a.m. the Nursing Home Administrator and Maintenance Supervisor Employee E15 confirmed that the facility failed to maintain a comprehensive program for water management to monitor the potential development and spread of Legionella and failed to implement control measures for Legionella within the facility. Review of the clinical record revealed Resident R36 was admitted to the facility on 10/2/20. Review of Resident R36's Minimum Data Set (MDS - a periodic assessment of care needs) dated 1/12/25, indicated diagnoses of anemia (too little iron in the body), Alzheimer's Disease (a progressive disease that destroys memory and other important mental functions), and hyperlipidemia (high levels of fat in the blood). Review of Section H	F 0880		

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F 0880 SS=D	Continued from page 68 - Bowel and Bladder, Question H0100 indicated the resident has an indwelling catheter. Section K - Swallowing/Nutritional Status, Question K05520B indicated the resident has a feeding tube. Review of Section M - Skin Conditions, Question M0300 indicated the resident has "2" Stage 4 pressure ulcers and "1" unstageable pressure ulcer. Review of a nursing progress note dated 10/10/24, stated, "New orders obtained for treatment of Shingles, husband updated." Review of Resident R36's clinical record failed to reveal documentation that the resident was placed in transmission-based precautions for Shingles on 10/10/24, and failed to reveal documentation that EBP were implemented related to Resident R36's wounds and indwelling medical devices. During an interview on 1/29/25, at 10:10 a.m. Registered Nurse (RN) Employee E2 stated, "I'm not sure if isolation precautions are in the physician orders or resident care plans, usually I find out by	F 0880		

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F 0880 SS=D	Continued from page 69 word of mouth." During an interview on 1/29/25, at 11:23 a.m. Infection Preventionist Employee E4 stated, "We placed in her Contact Precautions when she had shingles. We don't write orders for isolation precautions; we update the resident care plans to reflect any isolation precautions." During an interview on 1/29/25, at 12:11 p.m. Infection Preventionist Employee E4 confirmed there was no documentation in Resident R36's plan of care to reflect being placed in Contact Precautions for shingles and there was no documentation to implement EBP related to the resident's wounds and indwelling medical devices. During an interview on 1/29/25, at 12:11 p.m. Infection Preventionist Employee E4 confirmed that the facility failed to implement transmission-based precautions as required. 28 Pa. Code: 201.14(a) Responsibility of licensee.	F 0880		

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F 0880 SS=D	Continued from page 70 28 Pa. Code: 201.18(b)(1)(e)(1) Management.	F 0880		
F 0943 SS=D	483.95(c)(1)-(3) Abuse, Neglect, and Exploitation Training §483.95(c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on- §483.95(c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12. §483.95(c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property §483.95(c)(3) Dementia management and resident abuse prevention. This REQUIREMENT is not met as evidenced by:	F 0943	All employees with upcoming evaluations will have necessary required in-service education and training, including abuse and neglect, for total of 12 hours by their evaluation date. Employee training will be monitored and each employee's status of education completion will be pulled at least each quarter to ensure completion in a timely manner prior to evaluation date, by the staff development coordinator and Director of Nursing. Education to all nursing staff will be given by Staff Development or designee. QAPI on staff education training compliance will be done weekly for one month, bi-weekly for one month and monthly thereafter. All results will be reported to the QA Committee.	Completion Date: **03/07/2025** Status: **APPROVED** Date: **02/20/2025**

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F 0943 SS=D	Continued from page 71 Based on review of facility policy, facility personnel/in-service training records, and staff interview, it was determined that the facility failed to provide training on resident protection from abuse and neglect for one of seven staff members (Employee E8). Findings include: Review of the facility policy "Facility Assessment: Staff Training and Competencies" dated 5/23/24, indicated that all new staff are trained during the orientation process on designated facility topics. A checklist is completed both on theory and skills material. A checklist is completed again annually on both theory and skills material. Review of the facility policy "Prohibition and Prevention of resident Abuse, Neglect, Exploitation, Mistreatment, or Misappropriation of Resident Property "dated 5/23/24, indicated that all employees receive abuse training during general orientation and annually in conjunction with	F 0943		

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F 0943 SS=D	Continued from page 72 scheduled on-going training. Review of facility provided documents and training records revealed the following staff member did not have documented training on abuse and neglect. Nurse Aide (NA) Employee E8 had a hire date of 4/27/17, failed to have abuse and neglect prevention in-service education between 4/27/23, and 4/27/24. During an interview on 1/29/25, at 2:15 p.m. the Staff Development Coordinator Employee E14 confirmed that the facility failed to provide training on resident protection from abuse and neglect for one of seven staff members. 28 Pa Code: 201.14 (a) Responsibility of licensee. 28 Pa Code: 201.18 (b)(1) Management. 28 Pa Code: 201.20 (a)(c) Staff development.	F 0943		

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F 0944 SS=E	483.95(d) QAPI Training §483.95(d) Quality assurance and performance improvement. A facility must include as part of its QAPI program mandatory training that outlines and informs staff of the elements and goals of the facility's QAPI program as set forth at § 483.75. This REQUIREMENT is not met as evidenced by:	F 0944	All employees with upcoming evaluations will have necessary required in-service education and training, including QAPI, for total of 12 hours by their evaluation date. Employee training will be monitored and each employee's status of education completion will be pulled at least each quarter to ensure completion in a timely manner prior to evaluation date, by the staff development coordinator and Director of Nursing. Education to all nursing staff will be given by Staff Development or designee. QAPI on staff education training compliance will be done weekly for one month, bi-weekly for one month and monthly thereafter. All results will be reported to the QA Committee.	Completion Date: **03/07/2025** Status: **APPROVED** Date: **02/20/2025**

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F 0944 SS=E	Continued from page 74 Based on review of facility documents, employee education records, and staff interview, it was determined that the facility failed to provide training on QAPI (Quality Assurance and Performance Improvement) for five of seven staff members (Employee E7, E8, E9, E11, and E12) Findings include: Review of the facility policy "Facility Assessment: Staff Training and Competencies" dated 5/23/24, indicated that all new staff are trained during the orientation process on designated facility topics. A checklist is completed both on theory and skills material. A checklist is completed again annually on both theory and skills material. Review of facility provided documents and training records revealed the following staff members did not have documented training. Nurse Aide (NA) Employee E7 had a hire date of 3/12/20, failed to have QAPI education between	F 0944		

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F 0944 SS=E	Continued from page 75 3/12/23, and 3/12/24. NA Employee E8 had a hire date of 4/27/17, failed to have QAPI education between 4/27/23, and 4/27/24. NA Employee E9 had a hire date of 10/23/20, failed to have QAPI education between 10/23/23, and 10/23/24. NA Employee E11 had a hire date of 11/20/22, failed to have QAPI education between 11/20/23, and 11/20/24. Registered Nurse Employee E12 had a hire date of 7/12/16, failed to have QAPI education between 7/12/23, and 7/12/24. During an interview on 1/29/25, at 2:15 p.m. the Staff Development Coordinator Employee E14 confirmed that the facility failed to provide training on QAPI for five of seven staff members.	F 0944		

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F 0944 SS=E	Continued from page 76 28 Pa Code: 201.14 (a) Responsibility of licensee. 28 Pa Code: 201.18 (b)(1) Management. 28 Pa Code: 201.20 (a)(c) Staff development.	F 0944		
F 0947 SS=D	483.95(g)(1)-(4) Required In-Service Training for Nurse Aides §483.95(g) Required in-service training for nurse aides. In-service training must- §483.95(g)(1) Be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year. §483.95(g)(2) Include dementia management training and resident abuse prevention training. §483.95(g)(3) Address areas of weakness as determined in nurse aides' performance reviews and facility assessment at § 483.71 and may address the special needs of residents as determined by the facility staff. §483.95(g)(4) For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. This REQUIREMENT is not met as evidenced by:	F 0947	All CNA's with upcoming evaluations will have necessary required in-service education and training, for total of 12 hours by their evaluation date. CNA training will be monitored by staff development and Director of Nursing for education completion. Education status will be pulled, at least each quarter, to ensure completion in a timely manner, prior to evaluation date. Education to all CNA's will be given by Staff Development or designee. QAPI on staff education training compliance will be done weekly for one month, bi-weekly for one month and monthly thereafter. All results will be reported to the QA Committee.	Completion Date: **03/07/2025** Status: **APPROVED** Date: **02/20/2025**

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F 0947 SS=D	Continued from page 77	F 0947		

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F 0947 SS=D	Continued from page 78 Based on review of facility documents, employee education records, and staff interviews it was determined that the facility failed to ensure that all nurse aide staff received a minimum of twelve hours of in-service education training each year as required for two out of five Nurse Aide (NA) Employees (Employee E7, and E8) Findings include: Review of the facility policy "Facility Assessment: Staff Training and Competencies" dated 5/23/24, indicated that all new staff are trained during the orientation process on designated facility topics. A checklist is completed both on theory and skills material. A checklist is completed again annually on both theory and skills material. Review of facility provided documents and training records revealed the following staff members did not have documented training. NA Employee E7 had a hire date of 3/12/20, facility	F 0947		

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NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
ST. BARNABAS NURSING HOME STATE LICENSE NUMBER: **710302**	**5827 MERIDIAN ROAD** **GIBSONIA, PA 15044**

(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 0947 SS=D	Continued from page 79 provided information indicated that she had received 8.5 hours of in-services between 3/12/23, and 3/12/24 and did not meet the required 12 hours of in-servicing NA Employee E8 had a hire date of 4/27/17, facility provided information indicated that she had received 5.25 hours of in-services between 4/28/23, and 4/27/24, and did not meet the required 12 hours of in-servicing During an interview on 1/29/25, at 2:15 p.m. the Staff Development Coordinator Employee E14 confirmed that the facility failed to ensure that all NA received a minimum of 12 hours of in-service education training each year as required for two of five NA. 28 Pa. Code: 201.14(a) Responsibility of Licensee. 28 Pa. Code: 201.20(c) Staff Development.	F 0947		

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P 1020	Responsibility of licensee. (a) The licensee is responsible for meeting the minimum standards for the operation of a facility as set forth by the Department and by other Federal, State and local agencies responsible for the health and welfare of residents. This includes complying with all applicable Federal and State laws, and rules, regulations and orders issued by the Department and other Federal, State or local agencies. This REGULATION is not met as evidenced by:	P 1020	All 9 of the required Multidisciplinary team members will be present at the quarterly Infection Control/QAPI meeting. All members will be notified of when each quarterly Infection Control/QAPI meeting will be held and all signatures of those attending will be obtained. Members who attend via phone or video will be documented/signed as such for their attendance. Education will be provided to all Multidisciplinary team members by the RNAC or designee on their requirement to attend the Infection Control/QAPI meeting each quarter and to ensure they are signing the attendance log. Attendance/ signatures will be monitored at each quarterly Infection Control/QAPI meeting by the RNAC or designee.	Completion Date: **02/26/2025** Status: **APPROVED** Date: **02/20/2025**

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 (laboratory personnel, physical plant personnel, and pharmacy staff) 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 includes medical staff,	P 1020		

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P 1020	Continued from page 2 administration, laboratory personnel, nursing staff, pharmacy staff, physical plant personnel, patient safety officer, a community member, and a member of the infection control team. Review of the facility's Infection Control Committee Meeting attendance for Quarter 1 failed to reveal laboratory personnel were in attendance. Review of the facility's Infection Control Committee Meeting attendance for Quarter 2 failed to reveal laboratory personnel, physical plant personnel, and pharmacy staff were in attendance. Review of the facility's Infection Control Committee Meeting attendance for Quarter 3 failed to reveal laboratory personnel were in attendance. Review of the facility's Infection Control Committee Meeting attendance for Quarter 4 failed to reveal laboratory personnel were in attendance. During an interview on 1/30/25, at 12:35 p.m.	P 1020		

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P 1020	Continued from page 3 Infection Preventionist Employee E4 confirmed that the facility failed to ensure that all the required nine multidisciplinary members (laboratory personnel, physical plant personnel, and pharmacy staff) were present at the Infection Control Meetings for four of four quarters (Quarters 1, 2, 3, and 4 of 2024).	P 1020		
P 1560		P 1560		

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P 1560	Continued from page 4 Staff development. (2) Restorative nursing techniques. This REGULATION is not met as evidenced by:	P 1560	All employees with upcoming evaluations will have necessary required in-service education and training, including restorative, for total of 12 hours by their evaluation date. Employee training will be monitored and each employee's status of education completion will be pulled at least each quarter to ensure completion in a timely manner prior to evaluation date, by the staff development coordinator and Director of Nursing. Education to all nursing staff will be given by Staff Development or designee. QAPI on staff education training compliance will be done weekly for one month, bi-weekly for one month and monthly thereafter. All results will be reported to the QA Committee.	Completion Date: **03/07/2025** Status: **APPROVED** Date: **02/20/2025**

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P 1560	Continued from page 5 Based on a review of facility policy, facility documents, and staff interviews, it was determined that the facility failed to ensure that employees completed the required annual Restorative Nursing Techniques education for seven of seven employees reviewed (Employees E7, E8, E9, E10, E11, E12, and E13). Findings include: Review of the facility policy "Facility Assessment: Staff Training and Competencies" dated 5/23/24, indicated that all new staff are trained during the orientation process on designated facility topics. A checklist is completed both on theory and skills material. A checklist is completed again annually on both theory and skills material. Review of facility provided documents and training records revealed the following staff members did not have documented training. Nurse Aide (NA) Employee E7 had a hire date of	P 1560		

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P 1560	Continued from page 6 3/12/20, failed to include Restorative Nursing education between 3/12/23, and 3/12/24. NA Employee E8 had a hire date of 4/27/17, failed to include Restorative Nursing education between 4/27/23, and 4/27/24. NA Employee E9 had a hire date of 10/23/20, failed to include Restorative Nursing education between 10/23/23, and 10/23/24. NA Employee E10 had a hire date of 6/8/17, failed to include Restorative Nursing education between 6/8/23, and 6/28/24. NA Employee E11 had a hire date of 11/20/22, failed to include Restorative Nursing education between 11/20/23, and 11/20/24. Registered Nurse (RN) Employee E12 had a hire date of 7/12/16, failed to include Restorative Nursing education between 7/12/23, and 7/12/24.	P 1560		

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P 1560	Continued from page 7 RN Employee E13 had a hire date of 7/24/19, failed to include Restorative Nursing education between 7/24/23, and 7/24/24. During an interview on 1/29/25, at 2:00 p.m. the Nursing Home Administrator confirmed that the facility failed to provide training on Restorative Nursing for seven of seven staff members.	P 1560		
P 2590		P 2590		

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P 2590	Continued from page 8 Building Plans. (a) A licensee or prospective licensee shall submit its plans for construction, alteration or renovation to the Department. The Department will post instructions for submissions on its public website. This REGULATION is not met as evidenced by:	P 2590	Room 213 carpet was pulling up and posed a safety/tripping hazard. Resident was moved to another room temporarily on January 27,2025, to prevent injury. New vinyl flooring was installed on January 31, 2025. The resident returned to room 213 on January 31, 2025. Department of Health was emailed on January 29, 2025 and Life Safety was emailed on January 30, 2025 concerning changing the flooring due to safety. Reviewed information with Life safety via phone call on February 11, 2025. Life safety suggested using their web request and submit information on the flooring. Information submitted on February 14, 2025. All future flooring changes or other similar necessities of change will be reported to the Department of Health Supervisor and will be routed through the life safety portal for approval/notification. Education will be provided to the Director of maintenance. A QAPI will be initiated to ensure any change is reported to the appropriate authorities of the Department of	Completion Date: **02/14/2025** Status: **APPROVED** Date: **02/20/2025**

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P 2590	Continued from page 9	P 2590	Health and Life Safety. QA will be completed by the Director of maintenance or designee on a monthly basis and reported to the QA committee.	

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P 2590	Continued from page 10 Based on observations and staff interview it was determined that the facility failed to notify the Department of renovations made to one of three nursing units (Two North). Findings include: During an observation, and interview on 1/27/25, at 1:45 p.m. on Two North Unit, room 213 was empty with no furniture or bed, and Maintenance Workers were actively working on the room. Maintenance Worker Employee E5 stated that they began working on the room that day to replace the flooring and that the resident who had resided in that room had been relocated to another room while the room was under construction. During an interview on 1/29/25, at 1:51 p.m. the Nursing Home Administrator confirmed that the facility failed to notify the Department of renovations to Two North Room 213 prior to starting the renovations.	P 2590		

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P 3060	Function of building. (a) No part of a building may be used for a purpose which interferes with or jeopardizes the health and safety of residents. Special authorization shall be given by the Department ' s Division of Nursing Care Facilities if a part of the building is to be used for a purpose other than health care. This REGULATION is not met as evidenced by:	P 3060	In 2009, an exemption request was granted for the Personal care home, The Arbors to reside in the same building as St. Barnabas Nursing Home. Request submitted to the department of Health on February 14, 2025 for the Kitchen to prepare foods for the Personal Care Home and St. Barnabas Nursing Home as a second Waiver/exemption is required. Administrative Staff and Maintenance supervisor educated on requested waiver/exemption noted in PA 3060. QAPI will be completed to ensure the waiver/exemption is received from the Department of Health. Results will be reported in the QAPI meeting.	Completion Date: **02/14/2025** Status: **APPROVED** Date: **02/20/2025**

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P 3060	Continued from page 12 Based on observation and staff interview, it was determined that the facility failed to maintain kitchen area services designated for facility residents in three out of three nursing units (One South, Two North, and Two South), by failing to obtain permission from the State Licensing Agency to utilize the kitchen for Assisted Living Facilities (ALF). Findings Include: During an interview on 1/29/25, at 12:55 p.m. Dietary Supervisor Employee E6 stated that Long Term Care (LTC) Kitchen at the facility is also utilized to cook all meals for residents of the ALF located on the Third Floor and Courtyard Floor of the facility. During an interview on 1/20/25, at 1:50 p.m., the Nursing Home Administrator confirmed that the facility failed to maintain kitchen services designated for the facility residents and failed to file the appropriate waivers/exceptions to allow the LTC	P 3060		

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P 3060	Continued from page 13 kitchen to prepare foods for the ALF residents as required.	P 3060		
P 3310	Resident bedrooms. (a) A bed for a resident shall be placed only in a bedroom approved by the Department. This REGULATION is not met as evidenced by:	P 3310	There are rooms that are not immediately able to be set up as a patient room. A request to delicense beds will be submitted to the Department of Health. Education to the administrative staff, nursing and maintenance managers concerning what is needed for a functioning room and if we do not have a functioning room a bed may need delicensed. A QAPI will be completed monthly to ensure that the delicensing of beds was approved and all licensed beds are immediately available for a resident. Results will be reported to the QA committee.	Completion Date: **03/07/2025** Status: **APPROVED** Date: **02/20/2025**

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P 3310	Continued from page 14 Based on review of approved bed information, observations, and staff interview, it was determined that the facility failed to obtain the Department of Health's approval prior to removing beds from resident bedrooms. Findings include: During observations on all nursing units on 1/27/25, from 1:30 p.m. to 1:50 p.m. the following were observed: One North: Room 113 - licensed for three beds - zero beds are present. Room 114 - licensed for four beds - zero beds are present. Room 115 - licensed for four beds- zero beds are present. Room 116 - licensed for four beds - zero beds are present. Room 117 - licensed for four beds - zero beds are present.	P 3310		

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P 3310	Continued from page 15 Room 118 - licensed for four beds - zero beds are present. One South: Room 119 - licensed for two beds - has one bed. Room 120 - licensed for two beds - has one bed. Room 121 - licensed for two beds - has one bed. Room 122 - licensed for two beds - has one bed. Room 124- licensed for two beds - has one bed. Room 125- licensed for two beds - has one bed. Room 126- licensed for two beds - has one bed. Room 127- licensed for two beds - has one bed. Room 128- licensed for two beds - has one bed. Room 129- licensed for two beds - has one bed. Room 130- licensed for two beds - has one bed. Room 131- licensed for two beds - has one bed. Room 132- licensed for two beds - has one bed. Room 133- licensed for two beds - has one bed. Room 134- licensed for two beds - has one bed. Room 135- licensed for two beds - has one bed. Room 136- licensed for two beds - has one bed. Room 137- licensed for two beds - has one bed. Room 138- licensed for two beds - has one bed.	P 3310		

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P 3310	Continued from page 16 Two North: Room 201 - licensed for four beds - has one bed. Room 202- licensed for four beds - has two beds. Room 204- licensed for three beds - has one bed. Room 206 - licensed for three beds - has one bed. Room 213- licensed for three beds - zero beds are present- under construction. Room 214 - licensed for four beds - has one bed. Room 215 - licensed for four beds - has one bed. Room 216 - licensed for four beds - has one bed. Room 217 - licensed for four beds - has one bed. Room 218 - licensed for four beds - has one bed. Two South: Room 220 - licensed for four beds - has one bed. Room 222 - licensed for four beds - has one bed. Room 225 - licensed for two beds - has one bed. Room 226 - licensed for two beds - has one bed. Room 227 - licensed for two beds - has one bed. Room 228 - licensed for two beds - has one bed. Room 229 - licensed for two beds - has one bed. Room 231 - licensed for two beds - has one bed.	P 3310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395605	A. BLDG: 00 B. WING:	01/30/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
ST. BARNABAS NURSING HOME STATE LICENSE NUMBER: **710302**	**5827 MERIDIAN ROAD** **GIBSONIA, PA 15044**

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P 3310	Continued from page 17 Room 232 - licensed for two beds - has one bed. Room 233 - licensed for two beds - has one bed. Room 234 - licensed for two beds - has one bed. Room 236 - licensed for two beds - has one bed. Room 237 - licensed for two beds - has one bed. Room 238 - licensed for two beds - has one bed. Room 240 - licensed for two beds - has one bed. Room 241 - licensed for two beds - has one bed. Room 242 - licensed for two beds - has one bed. During an interview on 1/28/25, at 9:48 a.m. the Nursing Home Administrator (NHA) stated that all rooms on One North have been converted to offices and have no beds, and that most rooms on the other units have been converted to private rooms with one bed. NHA stated that the facility does not intend to convert the private rooms into semi-private or add any beds back into the rooms. NHA confirmed that the facility failed to obtain the Department of Health's approval prior to removing beds from resident bedrooms.	P 3310		

Certified End Page

ST. BARNABAS NURSING HOME

STATE LICENSE NUMBER: 710302

SURVEY EXIT DATE: 01/30/2025

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