

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395683</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>01/16/2025</b>
NAME OF PROVIDER OR SUPPLIER: <b>HIGHLANDS REHABILITATION AND HEALTHCARE</b>		STREET ADDRESS, CITY, STATE, ZIP CODE: <b>918 MAIN STREET LAPORTE, PA 18626</b>		
STATE LICENSE NUMBER: <b>127402</b>				
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F 0000	INITIAL COMMENT	F 0000		
F 0623	Based on a Medicare/Medicaid Recertification Survey, State Licensure Survey, Civil Rights Compliance Survey, and a Complaint Investigation completed on January 16, 2025, it was determined that Highlands Rehabilitation and Healthcare 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 Regulation as they relate to the Health portion of the survey process.	F 0623		
SS=B				

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=B	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	1. Facility cannot retroactively correct transfer notification to residents 59, 63, 91, 18, and 98. 2. Business office manager/designee completed an audit of the last month of discharges and any missed transfer notifications were addressed. 3. Nursing staff will be re-educated on providing notification to residents and resident representatives upon transfer out of the facility. 4. DON/designee will conduct random audits of transfers to verify proper notification weekly x4 and monthly x3. Results of audits will be reviewed by the Quality Assurance Performance Improvement Committee and changes will be made as necessary.	Completion Date: <b>02/25/2025</b> Status: <b>APPROVED</b> Date: <b>02/04/2025</b>

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F 0623  SS=B	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		

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F 0623  SS=B	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=B	Continued from page 4  Based on clinical record review and staff interview, it was determined that the facility failed to notify a resident and/or their responsible party in writing of a transfer to the hospital with the required information for five of five residents reviewed (Residents 18, 59, 63, 91, and 98).  Findings include:  Clinical record review for Resident 59 revealed that they were transferred to the hospital on December 1, 2024, after a change in their condition. There was no documentation that the facility provided written notification to the resident or the resident's responsible party regarding the transfer that included the required contents: reason for the transfer, effective date of the transfer, location to which the resident was transferred, a statement of the resident's right to appeal, including the name, contact, email, and address, how to obtain and appeal form, assistance completing and submitting the appeal form and hearing request, and contact, email, and address information for the Office of the	F 0623		

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F 0623  SS=B	Continued from page 5  State Long-Term Care Ombudsman, and information for the agency responsible for the protection and advocacy of individuals with developmental disabilities.  The surveyor reviewed the above information for during an interview with the Nursing Home Administrator and Director of Nursing on January 16, 2025, at 11:00 AM.  Clinical record review for Resident 91 revealed the resident was sent to the hospital on October 5, 2024, after a fall/change in condition and admitted.  Clinical record review for Resident 18 revealed the resident was sent to the hospital on December 7, 2024, for a change in condition and admitted.  Clinical record review for Resident 98 revealed the resident was sent to the hospital on November 3, 2024, for a change in condition and admitted. Resident 98 did not return to the facility .	F 0623		

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F 0623  SS=B	<p>Continued from page 6</p> <p>There was no evidence Resident 91 or 98's responsible party or Resident 18 and her responsible party were notified in writing of the transfer with the required contents noted above.</p> <p>There was no evidence the State Ombudsman was notified timely of the transfer for Resident 91 and 98.</p> <p>The nursing home administrator confirmed in an interview on January 16, 2025, at 10:14 AM the facility did not provide written notice of transfer as required to the resident's above and the facility had not submitted any transfer notices to the office of the stated ombudsman for September, October, and December 2024, until January 14, 2025, after it was brought to facility staff's attention during the survey process.</p> <p>Interview with Resident 63 on January 13, 2025, at 12:12 PM revealed that he was hospitalized with symptoms that were questionably indicative of a stroke (cerebrovascular accident, interruption of</p>	F 0623		

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F 0623  SS=B	<p>Continued from page 7</p> <p>blood flow or bleeding in the brain), but he returned to the facility after his hospitalization.</p> <p>Clinical record review for Resident 63 revealed nursing documentation dated September 28, 2024, at 6:55 PM that indicated Resident 63 was diaphoretic (sweating), had an altered mental status, reported that he was "going to pass out," and that he wanted to go to the hospital.</p> <p>Nursing documentation dated September 28, 2024, at 7:24 PM indicated that Resident 63 went to the hospital via an ambulance.</p> <p>Nursing documentation dated September 30, 2024, at 12:45 PM indicated that Resident 63 returned to the facility from the hospital.</p> <p>Nursing documentation dated October 12, 2024, at 12:24 PM indicated that Resident 63 was calling for help, had an elevated temperature, increased confusion, and agreed to transfer to the hospital for evaluation.</p>	F 0623		

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F 0623  SS=B	Continued from page 8  Nursing documentation dated October 12, 2024, at 12:47 PM revealed that Resident 63 left the facility via an ambulance in route to the hospital.  Nursing documentation dated October 12, 2024, at 1:25 PM revealed that staff spoke to Resident 63's sister to inform her of his transfer to the emergency department; however, the documentation did not indicate that staff forwarded a written notice that included the required contents to Resident 63's sister (resident representative).  Nursing documentation dated October 12, 2024, at 6:11 PM indicated that the emergency department admitted Resident 63 to the hospital.  The surveyor requested evidence that facility staff provided written notices of transfer to Resident 63, Resident 63's representative (sister), and the State Ombudsman when he was hospitalized on September 28, 2024, and October 12, 2024, during an interview with the Nursing Home	F 0623		

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F 0623  SS=B	Continued from page 9  Administrator and the Director of Nursing on January 14, 2025, at 1:30 PM, and January 15, 2025, at 12:28 PM and 2:07 PM.  The facility failed to provide evidence that Resident 63, his responsible party, or the State Ombudsman received the required written notices of transfers for the above hospitalizations.  28 Pa. Code 201.14 (a) Responsibility of license  28 Pa. Code 201.29(a) Resident rights	F 0623		
F 0625  SS=D		F 0625		

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F 0625  SS=D	Continued from page 10  483.15(d)(1)(2) Notice of Bed Hold Policy Before/Upon Trnsfr  §483.15(d) Notice of bed-hold policy and return-  §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section.  §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section.  This REQUIREMENT is not met as evidenced by:	F 0625	1. Facility cannot retroactively correct bed hold notification to resident 63. 2. Business office manager/designee completed an audit of the last month of discharges and any missed bed hold notifications were addressed. 3. Nursing staff will be re-educated on providing bed hold notification to residents and resident representatives upon transfer out of the facility. 4. DON/designee will conduct random audits of transfers to verify proper bed hold notification weekly x4 and monthly x3. Results of audits will be reviewed by the Quality Assurance Performance Improvement Committee and changes will be made as necessary.	Completion Date: <b>02/25/2025</b> Status: <b>APPROVED</b> Date: <b>02/04/2025</b>



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F 0625  SS=D	Continued from page 12  Based on resident interview, clinical record review, and staff and resident interview, it was determined that the facility failed to provide written notice regarding the facility's bed-hold policy for one of five residents reviewed for hospitalization concerns (Resident 63).  Findings include:  Interview with Resident 63 on January 13, 2025, at 12:12 PM revealed that he was hospitalized with symptoms that were questionably indicative of a stroke (cerebrovascular accident, interruption of blood flow or bleeding in the brain), but he returned to the facility after his hospitalization.  Clinical record review for Resident 63 revealed nursing documentation dated October 12, 2024, at 12:24 PM that indicated Resident 63 was calling for help, had an elevated temperature, increased confusion, and agreed to transfer to the hospital for evaluation.	F 0625		

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F 0625  SS=D	Continued from page 13  Nursing documentation dated October 12, 2024, at 12:47 PM revealed that Resident 63 left the facility via an ambulance in route to the hospital.  Nursing documentation dated October 12, 2024, at 1:25 PM revealed that staff spoke to Resident 63's sister to inform her of his transfer to the emergency department.  The documentation did not indicate that staff forwarded written information to Resident 63's sister (resident representative) regarding the facility's bed-hold policy.  Nursing documentation dated October 12, 2024, at 6:11 PM indicated that the emergency department admitted Resident 63 to the hospital.  Review of a Bed Hold Notice (document that the facility utilizes to communicate the duration of the bed-hold policy) dated October 12, 2024, revealed that staff documented, "Resident unable to sign," on October 14, 2024, on the signature line designated	F 0625		

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F 0625  SS=D	Continued from page 14  for the resident or resident representative name. The notice stipulated both that Resident 63 did not wish to authorize the facility to retain his bed and that he or his representative wanted to hold his bed for 15 days. The document did not indicate that staff forwarded written information to Resident 63's sister (resident representative) regarding the facility's bed-hold policy.  The surveyor requested evidence that facility staff provided written information to Resident 63 and Resident 63's representative (sister) regarding the facility's bed-hold policy at the time of his October 12, 2024, hospitalization during an interview with the Nursing Home Administrator and the Director of Nursing on January 14, 2025, at 1:30 PM, and January 15, 2025, at 12:28 PM and 2:07 PM.  The facility failed to provide evidence that Resident 63's responsible party received written information related to holding beds during absences from the facility within 24 hours of his emergency transfer.	F 0625		

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F 0625  SS=D	Continued from page 15  28 Pa. Code 201.14(a) Responsibility of license	F 0625		
F 0641  SS=D	28 Pa. Code 201.29(a) Resident rights 483.20(g) Accuracy of Assessments §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status.  This REQUIREMENT is not met as evidenced by:	F 0641	1. Resident 34's MDS was corrected. 2. Social services/designee completed an audit of residents with PASRR level 2 to verify Section A1500 is correct. 3. Social Service director was re-educated on completing accurate MDS assessments. 4. Social worker/designee will conduct random audits of PASRR level 2 residents to verify Section A1500 accuracy weekly x4 and monthly x3. Results of audits will be reviewed by the Quality Assurance Performance Improvement Committee and changes will be made as necessary.	Completion Date: <b>02/25/2025</b> Status: <b>APPROVED</b> Date: <b>02/04/2025</b>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395683</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>01/16/2025</b>	
NAME OF PROVIDER OR SUPPLIER: <b>HIGHLANDS REHABILITATION AND HEALTHCARE</b>  STATE LICENSE NUMBER: <b>127402</b>		STREET ADDRESS, CITY, STATE, ZIP CODE: <b>918 MAIN STREET LAPORTE, PA 18626</b>		
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F 0641  SS=D	<p>Continued from page 16</p> <p>Based on clinical record review and staff interview, it was determined that the facility failed to ensure a complete and accurate Minimum Data Set (MDS) assessment for one of 22 residents reviewed (Resident 34).</p> <p>Findings include:</p> <p>Review of Resident 34's clinical record revealed that the facility admitted her with a diagnosis of Schizophrenia.</p> <p>Further review revealed a PASRR (Pennsylvania Preadmission Screening Resident Review Identification Level 1 form) completed on May 22, 2019, that indicated the resident had a mental health condition or suspected mental illness that may lead to a chronic disability and the resident met the criteria (positive screen) to have a PASRR Level 2 evaluation done.</p> <p>A completed PASRR Level 2 by the Pennsylvania Department of Human Services Office on Mental</p>	F 0641		

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F 0641  SS=D	<p>Continued from page 17</p> <p>Health and Substance abuse services dated August 1, 2019, indicated Resident 34 had evidence of a Mental Health condition that met the criteria, and the resident was determined as eligible for Mental Health services.</p> <p>Review of Resident 34's last comprehensive (annual) MDS (minimum Data set - an assessment completed at periodic intervals of time to determine resident care needs) completed on May 6, 2024, revealed facility staff assessed the resident as not being considered by the state level II PASRR process to have a serious mental illness and/or intellectual disability or a related condition.</p> <p>The above information was reviewed with the Nursing Home Administrator and Director of Nursing on January 15, 2025, at 2:00 PM.</p> <p>The Nursing Home Administrator confirmed on January 16, 2025, at 9:38 AM the MDS noted above for Resident 34 was not accurately completed and the facility submitted a corrected</p>	F 0641		

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F 0641  SS=D	Continued from page 18  MDS after the information was reviewed as noted above.  28 Pa. Code 211.5(f)(ix) Medical records  28 Pa. Code 211.12(d)(1)(5) Nursing services	F 0641		
F 0657  SS=D		F 0657		

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F 0657  SS=D	Continued from page 19  483.21(b)(2)(i)-(iii) Care Plan Timing and Revision  §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.  This REQUIREMENT is not met as evidenced by:	F 0657	1. Resident 79's care plan was updated to include attempt care with 1 staff member and their tasks updated to include providing a diet coke. Resident 81's care plan was updated with a dental plan of care. Resident 86's care plan was updated with her current dental status. Resident 81's care plan was updated to include a dental plan. Resident 86's care plan was updated with her current dental status. Results of audits will be reviewed by the Quality Assurance Performance Improvement Committee and changes will be made as necessary. 2. Care conferences and consultant dental visit notes from the last 30 days were reviewed by RNAC/designee to verify any interventions/changes that were noted were added to the resident's care plan. 3. DON or designee will re-educate IDT and licensed staff on care planning and consultant dental visit interventions/changes. 4. DON or designee will complete random audits of care plan meetings	Completion Date: <b>02/25/2025</b> Status: <b>APPROVED</b> Date: <b>02/04/2025</b>

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F 0657  SS=D	Continued from page 20	F 0657	and consultant dental visit notes to verify interventions/changes are discussed are added to the resident's care plan and captured on the MDS weekly X 4 then monthly X 3 Results of the audits will be reviewed by the Quality Assurance Performance Improvement Committee and changes will be made as necessary.	

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F 0657  SS=D	Continued from page 21  Based on clinical record review and resident, family, and staff interview, it was determined that the facility failed to revise residents' care plans for three of 21 residents reviewed (Residents 79, 81, and 86).  Findings include:  Interview with Resident 79's daughter on January 13, 2025, at 10:29 AM indicated that she believed that her mother could become verbally and/or physically abusive to staff when she gets anxious. She stated that she believed that her mother has an anxious response when approached by two staff to perform care and that she suggested to the facility that her mother receive care by one staff. Resident 79's daughter also indicated that she provides soda for staff to give her mother to provide caffeine since she no longer smokes cigarettes or drinks coffee to lessen her behaviors and improve her compliance with care.  Clinical record review for Resident 79 revealed social services documentation dated November 26,	F 0657		

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F 0657  SS=D	Continued from page 22  2024, at 1:39 PM that during a care plan meeting, Resident 79's daughter expressed concerns that Resident 79 may be more combative in the morning with care because she no longer smokes cigarettes or drinks coffee. Resident 79's daughter provided diet soda for Resident 79 to have in the morning to provide some caffeine. Resident 79's daughter also suggested attempting care with only one staff member to see if Resident 79 would be less combative. The documentation indicated that staff updated resident 79's care plan.  Plans of care developed by the facility to record Resident 79's problem areas, goals, and interventions revealed areas that addressed Resident 79's impaired cognitive function related to dementia (decline in cognitive function that affects memory, thinking, judgement, and behavior); psychotropic medication use to treat dementia, depression, and anxiety; behaviors that include physical aggression and resistance to care; and communication deficits due to dementia.	F 0657		

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F 0657  SS=D	<p>Continued from page 23</p> <p>The plans of care did not include an intervention to attempt care with one staff to minimize Resident 79's anxiety, aggression, and refusal to cooperate with care.</p> <p>Review of Task Documentation (electronic documentation by nurse aide staff to record care provided and the level of staff assistance utilized) dated November 2024, revealed that two staff provided assistance with dressing and transfers November 27 through 30, 2024. Two staff provided assistance with personal hygiene on November 27 and 28, 2024.</p> <p>The November 2024, documentation did not indicate that staff offered the diet soda to Resident 79.</p> <p>Review of Task Documentation dated December 2024, revealed that two staff provided Resident 79 assistance with dressing on 27 of the 31 days reviewed; with transfers on 22 of the 31 days reviewed; and with personal hygiene on 25 of the 31</p>	F 0657		

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F 0657  SS=D	Continued from page 24  days reviewed.  The December 2024, documentation did not indicate that staff offered the diet soda to Resident 79.  Review of Task Documentation dated January 1 through 16, 2025, revealed that two staff provided Resident 79 assistance with dressing on 12 of the 16 days reviewed; and with personal hygiene on 11 of the 16 days reviewed.  The January 2025, documentation did not indicate that staff offered the diet soda to Resident 79.  Interview with Employee 1 (nurse aide) on January 16, 2025, at 11:05 AM revealed that she often provides care to Resident 79. Employee 1 stated staff, "typically go in with two (staff)," to provide Resident 79's care. Employee 1 stated that two staff provide care because Resident 79 is combative. Employee 1 confirmed that staff do not document that care was unsuccessfully attempted by	F 0657		

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F 0657  SS=D	Continued from page 25  one staff before two staff attempt to provide care. Employee 1 also confirmed that there was no instruction in the nurse aide computer tablet (that is used to inform nurse aide staff of resident care needs) to provide Resident 79 a diet soda.  Interview with the Nursing Home Administrator and the Director of Nursing on January 16, 2025, at 10:36 AM confirmed that Resident 79's plans of care did not include the new intervention to attempt care with one staff assistance. The interview also confirmed that the available documentation failed to indicate that staff offer Resident 79 a diet soda as part of her daily care.  Interview with Resident 81 on January 14, 2025, at 11:54 AM revealed that he has a tooth that is "bothering" him.  Clinical record review for Resident 81 revealed documentation by the facility's consultant dentist dated January 11, 2024, that Resident 81 had two missing teeth and retained roots (fragments of the	F 0657		

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F 0657  SS=D	Continued from page 26  tooth roots that remain in the jawbone after tooth loss or extraction) for three teeth (tooth number four, 17, and 32).  Documentation by the facility's consultant dentist dated March 22, 2024, indicated that the facility referred Resident 81 for services due to a complaint of tooth pain.  An annual MDS (Minimum Data Set, an assessment tool completed at specific intervals to determine resident care needs) dated June 8, 2024, assessed Resident 81 without any obvious or likely cavity or broken natural teeth. The MDS assessment did not trigger facility staff to develop a plan of care to address Resident 81's potential for dental health concerns.  Interview with Employee 2 (registered nurse assessment coordinator) on January 16, 2025, at 12:00 PM indicated that she did not review the dental progress notes when completing the MDS assessment. Employee 2 confirmed the June 8,	F 0657		

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F 0657  SS=D	<p>Continued from page 27</p> <p>2024, annual MDS assessment was inaccurate and because the assessment did not note Resident 81's broken teeth, the assessment did not trigger a dental care area that required a plan of care.</p> <p>Documentation by the facility's consultant dentist dated July 8, 2024, indicated that Resident 81's thirteenth tooth was, "non-restorable (tooth damage that cannot be fixed to prevent the tooth from removal);" and that he recommended extraction of the tooth as needed. Resident 81 did not exhibit symptoms to warrant extraction at that time.</p> <p>Nursing documentation dated December 19, 2024, at 9:42 AM indicated that Resident 81 complained of a toothache, and the physician provided a new order to refer Resident 81 to a dentist.</p> <p>Nutritional staff documentation dated December 25, 2024, at 6:00 PM noted that Resident 81 complained of tooth pain. The writer indicated that it was difficult to see which tooth was symptomatic "due to multiple decaying teeth."</p>	F 0657		

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F 0657  SS=D	<p>Continued from page 28</p> <p>Interview with the Director of Nursing and the Nursing Home Administrator on January 15, 2025, at 12:28 PM confirmed that no plan of care was developed or revised to include the above available information that Resident 81 had episodes of tooth pain, had retained tooth roots, and had multiple decaying teeth.</p> <p>Interview with Resident 86 on January 14, 2025, at 11:37 AM revealed that she had partial dentures for her upper and lower jaw but they "went missing." Resident 86 stated that "they (the facility's consultant dental provider) are supposed to be making new ones." Resident 86 indicated that it was eight months to one year that she did not have her partial dentures.</p> <p>Progress note documentation by the facility's consultant dental provider dated October 29, 2024, revealed that Resident 86 presented for an assessment of her bite for the casts (molds) of upper and lower partial dentures. The documentation</p>	F 0657		

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F 0657  SS=D	Continued from page 29  indicated that it was the second assessment of Resident 86's bite.  Review of a plan of care created by the facility on Resident 86's admission date of December 8, 2023, to address her self-care deficits in her activities of daily living (ADL), revealed that she had partial upper and lower dentures. Facility staff did not revise this plan of care to reflect Resident 86's missing partial dentures.  Interview with the Nursing Home Administrator and the Director of Nursing on January 15, 2025, at 12:20 PM confirmed that facility staff did not revise Resident 86's plan of care in response to Resident 86's missing partial dentures.  28 Pa. Code 211.12(d)(1)(3)(5) Nursing services	F 0657		
F 0676  SS=D		F 0676		

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F 0676  SS=D	Continued from page 30  483.24(a)(1)(b)(1)-(5)(i)-(iii) Activities Daily Living (ADLs)/Mntn Abilities  §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that:  §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ...  §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living:  §483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care,  §483.24(b)(2) Mobility-transfer and ambulation, including walking,  §483.24(b)(3) Elimination-toileting,	F 0676	1. Facility cannot retroactively provide restorative program to Resident 12 the days restorative was not completed. Resident 12 is currently receiving physical therapy. 2. DON/designee audited documentation from the last week of residents receiving restorative nursing program to verify residents are provided their program. 3. CNAs will be re-educated on the documentation of and providing restorative nursing services. 4. DON/designee will audit 5 random residents on a restorative nursing program weekly x4 and monthly x3. Results of audits will be reviewed by the Quality Assurance Performance Improvement Committee and changes will be made as necessary.	Completion Date: <b>02/25/2025</b> Status: <b>APPROVED</b> Date: <b>02/04/2025</b>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395683</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>01/16/2025</b>	
NAME OF PROVIDER OR SUPPLIER: <b>HIGHLANDS REHABILITATION AND HEALTHCARE</b>  STATE LICENSE NUMBER: <b>127402</b>		STREET ADDRESS, CITY, STATE, ZIP CODE: <b>918 MAIN STREET LAPORTE, PA 18626</b>		
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F 0676  SS=D	Continued from page 31  §483.24(b)(4) Dining-eating, including meals and snacks,  §483.24(b)(5) Communication, including (i) Speech, (ii) Language, (iii) Other functional communication systems.  This REQUIREMENT is not met as evidenced by:	F 0676		

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F 0676  SS=D	Continued from page 32  Based on clinical record review and resident and staff interview, it was determined that the facility failed to provide care and services to maintain or improve the ability to perform activities of daily living for one of two residents reviewed for rehabilitation concerns (Resident 12).  Findings include:  Interview with Resident 12 on January 13, 2025, at 12:58 PM revealed that she had a walker device in her room that is used when staff walk with her; however, that does not occur, "too much because they (the facility) don't have too many people (staff)."  A discharge summary by physical therapy staff dated November 29, 2023, indicated that services included patient and caregiver training, and instruction regarding an in-home exercise program (HEP) to preserve Resident 12's current level of function and prevent functional decline. Resident 12's prognosis was assessed as good with	F 0676		

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F 0676  SS=D	Continued from page 33  consistent staff follow-through. Discharge recommendations included that Resident 12 was to continue with the HEP restorative nursing program for gait and independent transfers and wheelchair mobility.  Review of Task Documentation (electronic documentation by nurse aide staff to record care provided and the level of staff assistance utilized) dated November 2024, revealed that staff documented Resident 12's program to ambulate for 100 feet was not applicable (NA) on November 12 and 27, 2024. Staff documented that Resident 12 refused to ambulate on eight days; however, there was no indication that staff re-approached Resident 12 to give her an opportunity to complete the program after her initial refusal on seven of the eight occasions.  Nursing documentation dated December 3, 2024, at 10:55 AM revealed that staff reviewed Resident 12's nursing ambulation program and made no changes at that time.	F 0676		

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F 0676  SS=D	Continued from page 34  Review of Task Documentation dated December 2024, revealed that staff documented Resident 12's program to ambulate for 100 feet was, "NA," on December 9, 10, and 24, 2024. Staff documented that Resident 12 refused the program on December 1, 6, 8, 17, 19, 23, 25, 30, and 31, 2024; however, there was no indication that staff re-approached Resident 12 to give her an opportunity to complete the program after her initial refusal on those nine days. Staff documented that Resident 12 completed the program on only 19 of the 31 days reviewed for December 2024.  Review of Task Documentation dated January 1 through 15, 2025, revealed that staff documented Resident 12's program to ambulate for 100 feet was, "NA," on January 2, 4, 9, and 13, 2025. Staff documented that Resident 12 refused the program on January 5, 6, 12, and 15, 2025; however, there was no indication that staff re-approached Resident 12 to give her an opportunity to complete the program after her initial refusal on those four days.	F 0676		

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F 0676  SS=D	Continued from page 35  Staff documented that Resident 12 completed the program on only seven of the 15 days reviewed for January 2025.  The surveyor reviewed the above concerns regarding Resident 12's restorative nursing program for ambulation during an interview with the Nursing Home Administrator and the Director of Nursing on January 16, 2025, at 10:36 AM.  28 Pa. Code 211.12(d)(1)(3)(5) Nursing services	F 0676		
F 0688  SS=E		F 0688		

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F 0688  SS=E	Continued from page 36  483.25(c)(1)-(3) Increase/Prevent Decrease in ROM/Mobility  §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and  §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.  §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable.  This REQUIREMENT is not met as evidenced by:	F 0688	1. Residents 19,48, 59 and 74 had their restorative programs reevaluated. 2. DON/designee audited current residents on a restorative program and were reevaluated with specific frequency. 3. Therapy/licensed staff will be re-educated on providing nursing with a frequency the restorative nursing program should be conducted. 4. NHA/designee will audit 5 random residents receiving restorative services to verify there is a frequency weekly x4 and monthly x3. Results of audits will be reviewed by the Quality Assurance Performance Improvement Committee and changes will be made as necessary.	Completion Date: <b>02/25/2025</b> Status: <b>APPROVED</b> Date: <b>02/04/2025</b>

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F 0688  SS=E	Continued from page 37  Based on review of select facility policies, clinical record review, and staff interview, it was determined that the facility failed to provide services to maintain or improve a resident's range of motion (ROM) and mobility for four of five residents reviewed (Resident 19, 48, 59, and 74).  Findings include:  Review of the facility policy entitled, "Restorative Nursing Services," last reviewed without changes on August 15, 2024, revealed that residents will receive restorative nursing care as needed to help promote optimal safety and independence. Restorative nursing care consists of nursing interventions that may or may not be accompanied by formalized rehabilitative services. Restorative goals and objectives are individualized and resident-centered and outlined in the resident's plan of care. Restorative goals may include but are not limited to supporting and assisting the resident in adjusting or adapting to changing abilities; developing, maintaining, or strengthening their physiological and	F 0688		

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F 0688  SS=E	Continued from page 38  psychological resources; maintaining their dignity, independence, and self-esteem; and participate in development and implementation of their plan of care. The policy does not speak to the expectations and frequency (how often) staff are to complete the resident's restorative nursing program interventions.  Clinical record review for Residents 19 revealed a therapy restorative referral dated November 8, 2024, which identified they had a decrease in their active ROM (movement of the body to maintain a resident's ability). Therapy staff indicated nursing staff should provide PROM (passive range of motion) to their BLE's (bilateral [both] lower extremities [legs]) for 10 repetitions, all available planes, and ranges. Therapy staff did not indicate the frequency (how often) or specific shift(s) that nursing staff should complete Resident 19's restorative nursing program.  Review of Resident 19's task documentation for Resident 19 revealed that nursing staff implemented their PROM restorative nursing program during	F 0688		

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F 0688  SS=E	Continued from page 39  each shift, however, opened the PROM task to be completed/documented only during day shift. There was no documentation that staff completed Resident 19's PROM restorative nursing program during evening or night shifts throughout the three months (November and December 2024, and January 2025) reviewed.  Clinical record review for Residents 48 revealed a therapy restorative referral dated November 26, 2024, which identified they had a decrease in their independent ambulation. Therapy staff indicated nursing staff should ambulate Resident 48 up to 110 feet with a FWW (front wheeled walker) with assist of one and w/c (wheelchair) to follow for safety. Therapy staff did not indicate the frequency (how often) or specific shift(s) that nursing staff should complete Resident 48's restorative nursing program.  Review of task documentation for Resident 48 revealed that nursing staff implemented their ambulation restorative nursing program during each shift, however, opened the ambulation task to be	F 0688		

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F 0688  SS=E	Continued from page 40  completed/documented only during day shift. There was no documentation that staff completed Resident 48's ambulation restorative nursing program during evening or night shifts throughout the three months (November and December 2024, and January 2025) reviewed. Further review revealed that staff noted "NA" (not applicable) for Resident 48's ambulation restorative nursing program on December 15, 2024, day shift.  Further review for Residents 48 revealed a therapy restorative referral dated January 7, 2025, which identified they had a decrease in AROM active range of motion) for their right elbow. Therapy staff indicated nursing staff should perform slow, gentle, and sustained PROM to their right elbow into extension for 2 sets of 10 repetitions for joint integrity/mobility. Therapy staff did not indicate the frequency (how often) or specific shift(s) that nursing staff should complete Resident 48's restorative nursing program. Nursing staff initialed the therapy referral, which indicated that they acknowledged the information and implemented the therapist's	F 0688		

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F 0688  SS=E	Continued from page 41  restorative program.  Review of task documentation for Resident 48 revealed that they had an AROM restorative nursing program for their RUE (right upper extremity) and right elbow, 2 sets of 10 repetitions in sitting position for every shift already implemented when therapy made the PROM restorative referral to nursing staff. There was no documentation that nursing staff discontinued Resident 48's AROM restorative nursing program and implemented their PROM restorative nursing program as indicated by therapy's restorative referral.  Clinical record review for Residents 59 revealed a therapy restorative referral dated January 1, 2025, which identified they had a decrease in ROM for their BLE's and RUE (right upper extremity [arm]). Therapy staff indicated nursing staff should provide PROM to their BLE's and LUE (left upper extremity) for 10 repetitions, all available planes, and ranges to prevent decline in current ROM. Therapy staff did not indicate the frequency (how	F 0688		

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F 0688  SS=E	Continued from page 42  often) or specific shift(s) that nursing staff should complete Resident 59's restorative nursing program and indicated the decline was in Resident 59's RUE but implemented a restorative nursing program for their LUE. Therapy did not address the noted RUE decline in their restorative referral.  Review of task documentation for Resident 59 revealed that nursing staff implemented that their PROM restorative nursing program during each shift, however, opened the PROM task to be completed/documented only during day and evening shift. Nursing staff also added "with a.m. (morning) and p.m. (afternoon) care" to the ROM task.  Clinical record review for Residents 74 revealed therapy restorative referral dated September 23, 2024, which identified they had a concern with the flexion of their RUE. Therapy staff indicated nursing staff should perform slow, gentle, sustained PROM exercised right hand digits 2 - 5 into extension, positive wrist mobility, and place resting orthotic (splint) on the right hand for skin integrity,	F 0688		

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F 0688  SS=E	Continued from page 43  contracture management, and joint alignment. Therapy staff did not indicate the frequency (how often) or specific shift(s) that nursing staff should complete Resident 74's restorative nursing program.  Review of task documentation for Resident 74 revealed that nursing staff implemented their PROM restorative nursing program during each shift, however, opened the PROM task to be completed/documentated only during day shift. There was no documentation that staff completed Resident 74's restorative program on evening or night shifts. Further review revealed that staff indicated "NA" for the restorative program January 13, 2025, day shift.  Further review of Resident 74's task documentation revealed that nursing staff implemented the therapy restorative referral for their right hand orthotic, with staff to apply a right palm roll and forearm splint on the AM (morning) and remove at HS (hour of sleep). Staff may remove for care and ambulation. There was no documentation in the therapy restorative referral or a physician's order, which	F 0688		

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F 0688  SS=E	Continued from page 44  indicated when staff were to apply and/or remove Resident 74's orthotic, place a palm roll, or that staff may remove for care and/or ambulation. Further review revealed that staff indicated "NA" or failed to document task completion on the following dates:  Day Shift:  October 5, 7 and 31, 2024  Evening Shift:  December 7, 2024  The surveyor reviewed the above information on January 16, 2025, at 11:30 AM with the Nursing Home Administrator and the Director of Nursing.  28 Pa. Code 211.10(a)(c)(d) Resident care policies  28 Pa. Code 211.12(c)(d)(1)(3)(5) Nursing services	F 0688		

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F 0695  SS=D	<p>483.25(i) Respiratory/Tracheostomy Care and Suctioning</p> <p>§ 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning.</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by:</p>	F 0695	<ol style="list-style-type: none"> <li>1. Resident 63's order was revised to evaluate the need for supplemental oxygen.</li> <li>2. DON/designee conducted an audit of residents receiving oxygen to verify evaluation is conducted when indicated.</li> <li>3. Nursing staff will be re-educated on obtaining oxygenation saturation assessments if indicated.</li> <li>4. DON/designee will audit 5 random residents on oxygen to verify evaluation of oxygenation saturation when indicated weekly x4 and monthly x3. Results of audits will be reviewed by the Quality Assurance Performance Improvement Committee and changes will be made as necessary.</li> </ol>	<p>Completion Date: <b>02/25/2025</b></p> <p>Status: <b>APPROVED</b></p> <p>Date: <b>02/04/2025</b></p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395683</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>01/16/2025</b>	
NAME OF PROVIDER OR SUPPLIER: <b>HIGHLANDS REHABILITATION AND HEALTHCARE</b>  STATE LICENSE NUMBER: <b>127402</b>		STREET ADDRESS, CITY, STATE, ZIP CODE: <b>918 MAIN STREET LAPORTE, PA 18626</b>		
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F 0695  SS=D	Continued from page 46  Based on observation, clinical record review, and staff interview, it was determined that the facility failed to implement physician ordered supplemental oxygen consistent with professional standards of practice for one of one resident reviewed for supplemental oxygen concerns (Resident 63).  Findings include:  Clinical record review for Resident 63 revealed a physician's order dated November 11, 2024, for staff to administer supplemental oxygen at two liters per minute as needed to keep oxygen saturation levels above 90 percent, use as needed for oxygen saturations of less than 90 percent.  Review of Resident 63's medication administration records and treatment administration records (MAR and TAR, electronic documentation completed by staff to record the completion of medications and treatments) dated November 2024, December 2024, and January 2025, revealed that staff did not obtain routine assessments of Resident 63's	F 0695		

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F 0695  SS=D	Continued from page 47  oxygenation saturations to determine the need for supplemental oxygen.  Observation of Resident 63 on January 13, 2025, at 12:20 PM revealed no supplemental oxygen in use. Review of Resident 63's clinical record revealed no evidence that staff obtained an assessment of Resident 63's oxygen saturation to determine that he did not need supplemental oxygen.  The surveyor reviewed the above concern that Resident 63's supplemental oxygen was ordered to maintain an oxygenation saturation greater than 90 percent; however, staff are not obtaining oxygenation saturation assessments regularly during an interview with the Nursing Home Administrator and the Director of Nursing on January 14, 2025, at 2:15 PM.  The facility provided a revised physician order dated January 15, 2025, at 10:45 AM that would prompt staff every shift to evaluate Resident 63's need for supplemental oxygen.	F 0695		

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F 0695  SS=D	Continued from page 48	F 0695		
F 0744  SS=D	28 Pa. Code 211.12(d)(1)(5) Nursing services 483.40(b)(3) Treatment/Service for Dementia §483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being.  This REQUIREMENT is not met as evidenced by:	F 0744	1. Facility made revisions to individualize resident 43's care plan relating to her dementia. 2. Social services/designee reviewed residents with a dementia diagnosis to verify each had individualized dementia care plans. 3. Nursing staff and social services will be re-educated on implementing individualized person-centered care plans to address dementia and cognitive loss. 4. DON/designee will conduct random audits of 5 residents with dementia to verify their care plans are individualized weekly x4 and monthly x3. Results of audits will be reviewed by the Quality Assurance Performance Improvement Committee and changes will be made as necessary.	Completion Date: <b>02/25/2025</b> Status: <b>APPROVED</b> Date: <b>02/04/2025</b>

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F 0744  SS=D	Continued from page 49  Based on clinical record review and staff interview, it was determined that the facility failed to develop and implement an individualized person-centered care plan to address dementia and cognitive loss displayed by one of one resident reviewed (Resident 43).  Findings include:  Clinical record review for Resident 43 revealed the facility admitted her on October 31, 2024, with diagnosis including Dementia (loss of memory, language, problem-solving, and other thinking abilities that interfere with daily life). A review of Resident 43's most recent annual Minimum Data Set Assessment (MDS, a form completed at specific intervals to determine care needs) dated November 6, 2024, indicated that the facility assessed Resident 43 as having a diagnosis of dementia. The facility determined that a care plan for dementia and cognitive loss would be developed.  A review of Resident 43's care plan entitled	F 0744		

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F 0744  SS=D	Continued from page 50  "impaired cognitive function related to dementia" revealed that there was no indication that the facility had implemented an individualized person-centered care plan to address the resident's dementia and cognitive loss needs, until the surveyor brought it to their attention on January 15, 2025, at 11:30 AM.  The findings were reviewed with the Nursing Home Administrator and Director of Nursing on January 15, 2025, at 2:30 AM.  The facility failed to develop and implement an individualized person-centered care plan to address dementia and cognitive loss for Resident 43.  28 Pa Code 211.12 (d)(1)(3)(5) Nursing services	F 0744		
F 0791  SS=D		F 0791		

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F 0791  SS=D	Continued from page 51  483.55(b)(1)-(5) Routine/Emergency Dental Srvcs in NFs  §483.55 Dental Services The facility must assist residents in obtaining routine and 24-hour emergency dental care.  §483.55(b) Nursing Facilities. The facility-  §483.55(b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(f) of this part, the following dental services to meet the needs of each resident: (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services;  §483.55(b)(2) Must, if necessary or if requested, assist the resident- (i) In making appointments; and (ii) By arranging for transportation to and from the dental services locations;  §483.55(b)(3) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay;	F 0791	1. Resident 86 has a follow up dental appointment to receive her new partials. 2. Social services/designee conducted an audit of residents with partial/ dentures to verify all are accounted for. Findings were addressed at the time of the audit. 3. Social services will be re-educated on notifying dental services within 3 days after partial/dentures are reported missing. 4. Unit manager/designee will conduct random audits of 5 residents with partial/ dentures to verify they are accounted for weekly x4 and monthly x3. Results of audits will be reviewed by the Quality Assurance Performance Improvement Committee and changes will be made as necessary.	Completion Date: <b>02/25/2025</b> Status: <b>APPROVED</b> Date: <b>02/04/2025</b>

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F 0791  SS=D	Continued from page 52  §483.55(b)(4) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; and  §483.55(b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan.  This REQUIREMENT is not met as evidenced by:	F 0791		

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F 0791  SS=D	Continued from page 53  Based on clinical record review, observation, and resident and staff interview, it was determined that the facility failed to provide routine dental services related to partial dentures for one of two residents reviewed for dental concerns (Resident 86).  Findings include:  Interview with Resident 86 on January 14, 2025, at 11:37 AM revealed that she had partial dentures for her upper and lower jaw but they "went missing." Resident 86 stated that "they (the facility's consultant dental provider) are supposed to be making new ones." Resident 86 indicated that it was eight months to one year that she did not have her partial dentures. Observation of Resident 86 on the date and time of the interview revealed that she had natural teeth and was missing teeth.  Clinical record review for Resident 86 revealed a plan of care created by the facility on Resident 86's admission date of December 8, 2023, to address her self-care deficits in her activities of daily living	F 0791		

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F 0791  SS=D	Continued from page 54  (ADL). The plan of care noted that Resident 86 had partial upper and lower dentures.  Progress note documentation by the facility's consultant dental provider dated October 29, 2024, revealed that Resident 86 presented for an assessment of her bite for the casts (molds) of upper and lower partial dentures. The documentation indicated that it was the second assessment of Resident 86's bite.  Interview with the Nursing Home Administrator and the Director of Nursing on January 15, 2025, at 12:20 PM confirmed that the facility did not have a concern form, grievance form, or clinical record documentation to indicate when Resident 86's partial dentures became missing; however, confirmed that the consultant dental provider documentation dated October 29, 2024, stipulated that Resident 86 presented for an assessment of her bite for the molds of upper and lower partial dentures. The surveyor requested that the facility provide their policy or procedure when resident	F 0791		

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F 0791  SS=D	Continued from page 55  property (including dentures) is determined missing. The facility did not provide a policy that stipulated the facility's responsibilities when there is loss or damage of resident dentures.  28 Pa. Code 201.18(d) Management  28 Pa. Code 211.10(a) Resident care policies  28 Pa. Code 211.12(d)(1)(3)(5) Nursing services	F 0791		
F 0883  SS=D		F 0883		

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F 0883  SS=D	Continued from page 56  483.80(d)(1)(2) Influenza and Pneumococcal Immunizations  §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.  §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization;	F 0883	1. Facility cannot retroactively provide Influenza vaccine informed consent to resident 21 and 46's representatives. Facility cannot retroactively provide Pneumococcal vaccine informed consent to resident 46's representative. 2. Infection preventionist/designee conducted an audit of the last two weeks of influenza and pneumococcal vaccines given to verify resident representatives were provided the informed consent. 3. Infection preventionist will be re-educated on educating resident representatives on the Influenza and Pneumococcal vaccine informed consents prior to vaccination. 4. DON/designee will conduct random audits of Influenza and Pneumococcal vaccination consent forms weekly x4 and monthly x3. Results of audits will be reviewed by the Quality Assurance Performance Improvement Committee and changes will be made as necessary.	Completion Date: <b>02/25/2025</b> Status: <b>APPROVED</b> Date: <b>02/04/2025</b>

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F 0883  SS=D	Continued from page 57  (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.  This REQUIREMENT is not met as evidenced by:	F 0883		

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F 0883  SS=D	Continued from page 58  Based on clinical record review and staff interview, it was determined that the facility failed to ensure residents' medical records included documentation that residents' representatives were provided education regarding the risks and benefits of immunizations for two of five residents reviewed for immunization concerns (Residents 21 and 46).  Findings include:  Clinical record review for Resident 21 revealed a quarterly MDS (minimum data set, an assessment completed by the facility at intervals to determine care needs) assessment dated August 2, 2024, that indicated Resident 21 had a BIMS (Brief Interview for Mental Status) score of three, indicating she had severe cognitive impairment.  A psychiatric note dated October 4, 2024, at 12:00 PM indicated that Resident 21 was awake, alert, and oriented.  Review of Resident 21's Influenza Vaccination (a	F 0883		

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F 0883  SS=D	<p>Continued from page 59</p> <p>shot that protects against the flu) consent form revealed that there was no signature by the resident or her responsible party indicating that she received and understood the risk versus benefits of the vaccination. The form revealed that she received an Influenza Vaccination on October 14, 2024.</p> <p>Attempted interview of Resident 21 on January 15, 2024, at 11:50 AM revealed that she was unable to answer if she gave permission to be vaccinated with the influenza vaccination on October 14, 2024.</p> <p>The facility could not provide evidence that Resident 21 or her responsible party were given education regarding the risks and benefits of the influenza vaccination prior to it being administered on October 14, 2024.</p> <p>Clinical record review for Resident 46 revealed a quarterly MDS assessment dated September 27, 2024, that indicated Resident 46 had a BIMS score of three, indicating she had severe cognitive impairment.</p>	F 0883		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395683</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>01/16/2025</b>	
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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 0883  SS=D	Continued from page 60  A physician's progress note dated October 3, 2024, at 5:23 PM revealed that Resident 46 is alert with confusion and has a diagnosis of dementia (a group of thinking and social symptoms that interferes with daily functioning).  Review of Resident 46's Influenza Vaccination consent form revealed that Resident 46 signed the form but did not date it, indicating that she gave consent to receive the influenza vaccination and that she understood the risk versus benefits of the vaccination. The form also indicated that she received the vaccine on October 14, 2024.  Review of Resident 46's Pneumococcal Vaccination (a shot that protects against pneumonia) informed consent form revealed that Resident 46 signed it indicating that she received a copy of the pneumococcal vaccination education, but no date was present to indicate when she signed the form, and that she gave permission for the vaccine to be administered. The vaccine was administered on	F 0883		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395683</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>01/16/2025</b>
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F 0883  SS=D	Continued from page 61  December 10, 2024.  The facility could not provide evidence that Resident 46's responsible party was given education regarding the risks and benefits of the Influenza or the Pneumococcal vaccination (given Resident 46's incapacity to be her own responsible party for medical decisions) for her to make an informed decisions regarding the vaccination administration to Resident 46.  An interview with Employee 3, Infection preventionist, on January 16, 2025, at 10:00 AM confirmed the above noted findings for Residents 21 and 46.  The Nursing Home Administrator and Director of Nursing were made aware of the above noted concerns related to Resident 21 and 46's vaccinations on January 16, 2024, at 11:32 AM.  483.80(d)(1)(2) Influenza and Pneumococcal Immunizations	F 0883		

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F 0883  SS=D	Continued from page 62  Previously cited deficiency 2/9/24  28 Pa. Code 211.5(f) Medical records	F 0883		
F 0887  SS=D	28 Pa. Code 211.12(d)(1)(3)(5) Nursing services 483.80(d)(3)(i)-(vii) COVID-19 Immunization  §483.80(d) (3) COVID-19 immunizations. The LTC facility must develop and implement policies and procedures to ensure all the following: (i) When COVID-19 vaccine is available to the facility, each resident and staff member is offered the COVID-19 vaccine unless the immunization is medically contraindicated or the resident or staff member has already been immunized; (ii) Before offering COVID-19 vaccine, all staff members are provided with education regarding the benefits and risks and potential side effects associated with the vaccine; (iii) Before offering COVID-19 vaccine, each resident or the resident representative receives education regarding the benefits and risks and potential side effects associated with the COVID-19 vaccine; (iv) In situations where COVID-19 vaccination requires multiple doses, the resident, resident representative, or staff member is provided with current information regarding those additional doses,	F 0887	1. Facility cannot retroactively provide the COVID vaccine informed consent to resident 46's representative. 2. Infection preventionist/designee conducted an audit of the last two weeks of COVID vaccines given to verify resident representatives were provided the informed consent. 3. Infection preventionist will be re-educated on educating resident representatives on the COVID vaccine informed consent prior to vaccination. 4. DON/designee will conduct random audits of COVID vaccination consent forms weekly x4 and monthly x3. Results of audits will be reviewed by the Quality Assurance Performance Improvement Committee and changes will be made as necessary.	Completion Date: <b>02/25/2025</b> Status: <b>APPROVED</b> Date: <b>02/04/2025</b>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395683</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>01/16/2025</b>	
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F 0887  SS=D	Continued from page 63  including any changes in the benefits or risks and potential side effects associated with the COVID-19 vaccine, before requesting consent for administration of any additional doses; (v) The resident, resident representative, or staff member has the opportunity to accept or refuse a COVID-19 vaccine, and change their decision; (vi) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident representative was provided education regarding the benefits and potential risks associated with COVID-19 vaccine; and (B) Each dose of COVID-19 vaccine administered to the resident; or (C) If the resident did not receive the COVID-19 vaccine due to medical contraindications or refusal; and (vii) The facility maintains documentation related to staff COVID-19 vaccination that includes at a minimum, the following: (A) That staff were provided education regarding the benefits and potential risks associated with COVID-19 vaccine; (B) Staff were offered the COVID-19 vaccine or information on obtaining COVID-19 vaccine; and (C) The COVID-19 vaccine status of staff and related information as indicated by the Centers for Disease Control and Prevention's National Healthcare Safety Network	F 0887		

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F 0887  SS=D	Continued from page 64  (NHSN).  This REQUIREMENT is not met as evidenced by:	F 0887		

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F 0887  SS=D	Continued from page 65  Based on clinical record review and staff interview, it was determined that the facility failed to ensure a residents' medical records included documentation that the residents' representative was provided education regarding the risks and benefits of receiving a COVID-19 immunizations for one of five residents reviewed for immunization concerns (Residents 46).  Findings include:  Clinical record review for Resident 46 revealed a quarterly MDS assessment dated September 27, 2024, that indicated resident had a BIMS score of three, indicating she had severe cognitive impairment.  A physician's progress note dated October 3, 2024, at 5:23 PM revealed that Resident 46 is alert with confusion and has a diagnosis of dementia (a group of thinking and social symptoms that interferes with daily functioning).	F 0887		

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F 0887  SS=D	<p>Continued from page 66</p> <p>Review of Resident 46's COVID-19 vaccine consent/administration record provided by the facility, revealed that Resident 46 signed the form on November 7, 2024, indicating that she understood the benefits and risks of the vaccine and consented to receive the updated COVID vaccine. The form also indicated that Resident 46 received the COVID-19 vaccine on November 21, 2024.</p> <p>The facility could not provide evidence that Resident 46's responsible party was given education regarding the risks and benefits of the COVID-19 vaccination (given Resident 46's incapacity to be her own responsible party for medical decisions) for her to make an informed decision regarding the vaccination administration to Resident 46.</p> <p>An interview with Employee 3, Infection preventionist, on January 16, 2025, at 10:00 AM confirmed the above noted findings for Resident 46.</p> <p>The Nursing Home Administrator and Director of Nursing were made aware of the above noted</p>	F 0887		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395683</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>01/16/2025</b>
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F 0887  SS=D	Continued from page 67  concerns related to Resident 46 on January 16, 2024, at 11:32 AM.  483.80(d)(3)(i)-(vii) Covid-19 Immunization Previously cited deficiency 2/9/24  28 Pa. Code 201.14(a) Responsibility of licensee  28 Pa. Code 211.5(f) Medical records  28 Pa. Code 211.12(d)(1)(3)(5) Nursing services	F 0887		

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P 4860	<p>Medical records.</p> <p>(d) Records of discharged residents shall be completed within 30 days of discharge. Medical information pertaining to a resident ' s stay shall be centralized in the resident ' s record.</p> <p>This REGULATION is not met as evidenced by:</p>	P 4860	<ol style="list-style-type: none"> <li>1. Facility cannot retroactively provide resident 100's discharge summary.</li> <li>2. Medical records director/designee conducted an audit of the last 2 weeks of discharges to verify discharge summaries have been completed.</li> <li>3. Providers will be re-educated on providing discharge summaries.</li> <li>4. DON/designee will audit discharges to verify they have completed discharge summaries weekly x4 and monthly x3. Results of audits will be reviewed by the Quality Assurance Performance Improvement Committee and changes will be made as necessary.</li> </ol>	<p>Completion Date: <b>02/25/2025</b></p> <p>Status: <b>APPROVED</b></p> <p>Date: <b>02/04/2025</b></p>

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395683</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>01/16/2025</b>	
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P 4860	<p>Continued from page 1</p> <p>Based on a closed clinical record review and staff interview, it was determined that the facility failed to complete a discharge summary within 30 days of the resident's death for one of three closed records reviewed (Resident 100).</p> <p>Findings include:</p> <p>Closed clinical record review for Resident 100 revealed nursing documentation dated November 28, 2024, at 10:44 AM that noted the resident was without pulse or respirations and was pronounced deceased at 10:06 AM.</p> <p>Closed clinical record review for Resident 100 revealed no discharge summary, that also included the final diagnosis and cause of death, was completed within 30 days of the resident's death.</p> <p>The facility failed to complete a discharge summary for Resident 100.</p> <p>The Nursing Home Administrator and Director of</p>	P 4860		

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P 4860	Continued from page 2	P 4860		
P 5520	<p>Nursing were notified of the above findings on January 16, 2025, at 11:35 AM.</p> <p>Nursing services.</p> <p>(3) Effective July 1, 2024, a minimum of 1 nurse aide per 10 residents during the day, 1 nurse aide per 11 residents during the evening, and 1 nurse aide per 15 residents overnight.</p> <p>This REGULATION is not met as evidenced by:</p>	P 5520	<p>1. Facility cannot retroactively correct nurse aide staffing ratio.</p> <p>2. Director of Nursing/Designee will conduct an initial audit of the past two weeks' schedule to determine if nurse aide ratio is in compliance.</p> <p>3. Director of Nursing/Designee will re-educate the scheduler on the proper nurse aide staffing ratios. The facility will hold labor meetings Monday-Friday to verify ratios are made.</p> <p>4. Director of Nursing/Designee will conduct random audits of nurse aide staffing weekly for four weeks, then monthly for two months thereafter to verify proper nurse aide ratios. Results of audits will be reviewed by the Quality Assurance Performance Improvement Committee and changes will be made as necessary.</p>	<p>Completion Date: <b>02/25/2025</b></p> <p>Status: <b>APPROVED</b></p> <p>Date: <b>02/04/2025</b></p>

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P 5520	Continued from page 3  Based on a review of nursing staffing hours and staff interview, it was determined that the facility failed to ensure a minimum of one nurse aide (NA) per 11 residents during the evening shift for two of the 21 days reviewed; and a minimum of one NA per 15 residents during the overnight shift for three of the 21 days reviewed.  Findings include:  The team coordinator requested nurse staffing schedules during the onsite survey's entrance conference with the Director of Nursing on January 13, 2025, at 8:02 AM.  Email communication to the Director of Nursing and the Nursing Home Administrator on Monday, January 13, 2025, at 8:05 AM provided the specific dates required for nurse staffing review.  The surveyor reiterated the need for nurse staffing information during an interview with the Nursing Home Administrator and the Director of Nursing on	P 5520		

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P 5520	<p>Continued from page 4</p> <p>January 14, 2025, at 1:30 PM; and January 15, 2025, at 12:29 PM.</p> <p>Interview with Employee 4 (nurse aide/scheduler) on January 15, 2025, at 1:26 PM revealed that the facility counted staff for more than eight hours during an eight-hour shift (e.g., staff indicated as provided nine hours of care during a 6:00 AM to 2:00 PM shift) on numerous days for numerous staff. Employee 4 stated that those staff, "may have," clocked in early or stayed late after their shift; however, those hours were not credited to the correct shift. Employee 4 confirmed that all the staffing calculations would be incorrect based on that practice.</p> <p>The surveyor reiterated the need for correct nurse staffing information during an interview with the Nursing Home Administrator on January 16, 2025, at 8:50 AM.</p> <p>Interview with the Nursing Home Administrator and Employee 4 on January 16, 2025, at 12:02 PM</p>	P 5520		

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P 5520	Continued from page 5  confirmed that the facility still could not provide the requested nurse staffing information.  The facility provided nursing care hours on January 16, 2025, at 12:12 PM.  A review of nursing care hours provided by the facility for the dates of October 6 through 12, 2024; November 24 through 30, 2024; and January 9 through 15, 2025, revealed the following NAs scheduled for the resident census:  Evening shift (requires one NA per 11 residents):  October 7, 2024, 9.10 NAs for a census of 104, requires 9.45 NAs October 8, 2024, 9.27 NAs for a census of 104, requires 9.45 NAs  Night shift (requires one NA per 15 residents):  October 6, 2024, 6.73 NAs for a census of 103, requires 6.87 NAs	P 5520		

Pennsylvania Department of Health

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P 5520	Continued from page 6  October 11, 2024, 5.70 NAs for a census of 106, requires 7.07 NAs November 25, 2024, 6.33 NAs for a census of 102, requires 6.8 NAs  The surveyor reviewed the above concerns with the Nursing Home Administrator and the Director of Nursing on January 16, 2025, at 2:30 PM.	P 5520		
P 5530		P 5530		

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STATE LICENSE NUMBER: <b>127402</b>				
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P 5530	Continued from page 7  Nursing services.  (4) Effective July 1, 2023, a minimum of 1 LPN per 25 residents during the day, 1 LPN per 30 residents during the evening, and 1 LPN per 40 residents overnight.  This REGULATION is not met as evidenced by:	P 5530	1. Facility cannot retroactively correct LPN staffing ratio. 2. Director of Nursing/Designee will conduct an initial audit of the past two weeks schedule to determine if LPN ratio is in compliance. 3. Director of Nursing/Designee will re-educate the scheduler on the proper LPN staffing ratios. The facility will hold labor meetings Monday-Friday to verify ratios are made. 4. Director of Nursing/Designee will conduct random audits of LPN staffing weekly for four weeks, then monthly for two months thereafter to verify proper LPN ratios. Results of audits will be reviewed by the Quality Assurance Performance Improvement Committee and changes will be made as necessary.	Completion Date: <b>02/25/2025</b> Status: <b>APPROVED</b> Date: <b>02/04/2025</b>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395683</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>01/16/2025</b>	
NAME OF PROVIDER OR SUPPLIER: <b>HIGHLANDS REHABILITATION AND HEALTHCARE</b>  STATE LICENSE NUMBER: <b>127402</b>		STREET ADDRESS, CITY, STATE, ZIP CODE: <b>918 MAIN STREET LAPORTE, PA 18626</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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
P 5530	<p>Continued from page 8</p> <p>Based on a review of nursing staffing hours and staff interview, it was determined that the facility failed to ensure a minimum of one licensed practical nurse (LPN) per 25 residents during the day shift for two of the 21 days reviewed; and a minimum of one LPN per 40 residents during the overnight shift for one of the 21 days reviewed.</p> <p>Findings include:</p> <p>A review of nursing care hours provided by the facility for the dates of October 6 through 12, 2024; November 24 through 30, 2024; and January 9 through 15, 2025, revealed the following LPNs scheduled for the census:</p> <p>Day shift (requires one LPN per 25 residents):</p> <p>October 6, 2024, 4.03 LPNs for a census of 103, requires 4.12 LPNs November 24, 2024, 4.0 LPNs for a census of 103, requires 4.12 LPNs</p>	P 5530		

Pennsylvania Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395683</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>01/16/2025</b>
NAME OF PROVIDER OR SUPPLIER: <b>HIGHLANDS REHABILITATION AND HEALTHCARE</b>		STREET ADDRESS, CITY, STATE, ZIP CODE: <b>918 MAIN STREET LAPORTE, PA 18626</b>		
STATE LICENSE NUMBER: <b>127402</b>				
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P 5530	Continued from page 9  Overnight shift (requires one LPN per 40 residents):  October 12, 2024, 2.06 LPNs for a census of 104, requires 2.60 LPNs  The surveyor reviewed the above concerns with the Nursing Home Administrator and the Director of Nursing on January 16, 2025, at 2:30 PM.	P 5530		
P 5640		P 5640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395683</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>01/16/2025</b>
NAME OF PROVIDER OR SUPPLIER: <b>HIGHLANDS REHABILITATION AND HEALTHCARE</b>		STREET ADDRESS, CITY, STATE, ZIP CODE: <b>918 MAIN STREET LAPORTE, PA 18626</b>		
STATE LICENSE NUMBER: <b>127402</b>				
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P 5640	Continued from page 10  Nursing services.  (2) Effective July 1, 2024, the total number of hours of general nursing care provided in each 24-hour period shall, when totaled for the entire facility, be a minimum of 3.2 hours of direct resident care for each resident.  This REGULATION is not met as evidenced by:	P 5640	1. Facility cannot retroactively correct staffing PPD. 2. Director of Nursing/Designee will conduct an initial audit of the past two weeks' schedule to determine if PPD is in compliance. 3. Director of Nursing/Designee will re-educate the scheduler on the proper PPD. The facility will hold labor meetings Monday-Friday to verify PPD is made. 4. Director of Nursing/Designee will conduct random audits of facility PPD weekly for four weeks, then monthly for two months thereafter to verify proper PPD hours. Results of audits will be reviewed by the Quality Assurance Performance Improvement Committee and changes will be made as necessary.	Completion Date: <b>02/25/2025</b> Status: <b>APPROVED</b> Date: <b>02/04/2025</b>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395683</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>01/16/2025</b>
NAME OF PROVIDER OR SUPPLIER: <b>HIGHLANDS REHABILITATION AND HEALTHCARE</b>		STREET ADDRESS, CITY, STATE, ZIP CODE: <b>918 MAIN STREET LAPORTE, PA 18626</b>		
STATE LICENSE NUMBER: <b>127402</b>				
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P 5640	Continued from page 11  Based on a review of nursing staffing hours and staff interview, it was determined that the facility failed to ensure that the total of nursing care hours provided in each 24-hour period was a minimum of 3.2 hours per patient per day (PPD), effective July 1, 2024, for four of 21 days reviewed.  Findings include:  A review of nursing staff care hours provided by the facility for the dates of October 6 through 12, 2024; November 24 through 30, 2024; and January 9 through 15, 2025, revealed that the facility failed to meet the minimum hours PPD for the following days:  October 6, 2024, hours PPD 3.17 October 11, 2024, hours PPD 3.08 October 12, 2024, hours PPD 3.14 November 24, 2024, hours PPD 3.18  The surveyor reviewed the above concerns with the Nursing Home Administrator and the Director of Nursing on January 16, 2025, at 2:30 PM.	P 5640		



# Certified End Page

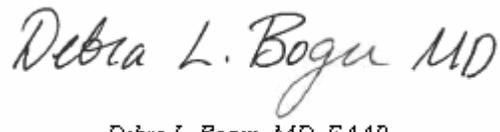
**HIGHLANDS REHABILITATION AND HEALTHCARE**

**STATE LICENSE NUMBER: 127402**

**SURVEY EXIT DATE: 01/16/2025**

**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, 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