STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395778	A. BLDG: 00 B. WING:	02/05/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
COMMUNITIES AT INDIAN HAVEN, THE STATE LICENSE NUMBER: **090102**	**1675 SALTSBURG AVENUE** **INDIANA, PA 15701**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0000	INITIAL COMMENT Based on a Medicare/Medicaid Recertification survey, State Licensure survey, and a Civil Rights Compliance survey completed on February 5, 2025, it was determined that The Communities at Indian Haven was not in compliance with the following requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities and the 28 PA Code, Commonwealth of Pennsylvania Long Term Care Licensure Regulations.	F 0000		
F 0638 SS=E		F 0638		

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 0638 SS=E	Continued from page 1 483.20(c) Qrtly Assessment at Least Every 3 Months §483.20(c) Quarterly Review Assessment A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced by:	F 0638	This plan of correction is prepared and executed because it is required by the provisions of the state and federal regulations and not because Communities at Indian Haven agrees with the allegations and citations listed on the statement of deficiencies. Communities at Indian Haven maintains that the alleged deficiencies do not, individually, and collectively, jeopardize the health and safety of the residents, nor are they of such character as to limit our capacity to render adequate care as prescribed by regulation. This plan of correction shall operate as Communities at Indian Haven's written credible allegation of compliance. By submitting this plan of correction, Communities at Indian Haven does not admit to the accuracy of the deficiencies. This plan of correction is not meant to establish any standard of care, contract, obligation, or position, and Communities at Indian Haven reserves all rights to raise all possible contentions and defenses in any civil or criminal claim, action	Completion Date: **03/30/2025** Status: **APPROVED** Date: **03/03/2025**

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F 0638 SS=E	Continued from page 2	F 0638	or proceeding. F638 1. The dates of submission for residents 19,33,35,38,43,54, and 62 cannot be altered. The residents suffered no harm from this action. 2. Any other Minimum Data Set submission has potential to be submitted late. 3. An evaluation of the scheduling and planning process was conducted to determine measures that could be implemented to prevent this deficient practice from recurring. The scheduling target was shortened to fall within required parameters. Education was done with the interdisciplinary team, and dates are being reviewed weekly. 4. A Performance Improvement Plan was started to review timely submissions for 3 months until new process is secured. An audit of submission dates will be done weekly x 4 and then monthly x2 and reported to the quality assessment team for review. Administrator or designee will monitor.	

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F 0638 SS=E	Continued from page 3 Based on review of the Resident Assessment Instrument User's Manual and clinical records, as well as staff interviews, it was determined that the facility failed to ensure that Quarterly Minimum Data Set assessments were completed within the required timeframe for seven of 43 residents reviewed (Residents 19, 33, 35, 38, 43, 54, 62). Findings include: The Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual, which provides instructions and guidelines for completing required Minimum Data Set (MDS) assessments (mandated assessments of residents' abilities and care needs), dated October 2024, indicated that the completion date for a quarterly assessment is the Assessment Reference Date (ARD - the last day of an assessment's look-back period) plus 14 days. A quarterly assessment is due every 92 days (ARD of most recent assessment + 92 days). A quarterly MDS assessment for Resident 19, with	F 0638		

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F 0638 SS=E	Continued from page 4 an ARD of September 3, 2024, was due to be completed on September 16, 2024; however, it was not completed until October 4, 2024, which was 18 days late. A quarterly MDS assessment for Resident 33, with an ARD of December 17, 2024, was due to be completed on December 31, 2024; however, it was not completed until January 1, 2025, which was one day late. A quarterly MDS assessment for Resident 35, with an ARD of August 7, 2024, and the next quarterly MDS assessment with an ARD of November 8, 2024, was to be completed on November 7, 2024, which was one day late for an assessment to be completed every 92 days. A quarterly MDS assessment for Resident 38, with an ARD of July 9, 2024, was due to be completed on July 23, 2024; however, it was not completed until July 26, 2024, which was three days late.	F 0638		

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F 0638 SS=E	Continued from page 5 A quarterly MDS assessment for Resident 43, with an ARD of July 12, 2024, was due to be completed on July 26, 2024; however, it was not completed until August 1, 2024, which was six days late. A quarterly MDS assessment for Resident 54, with an ARD of July 26, 2024, was due to be completed on August 9, 2024; however, it was not completed until August 26, 2024, which was 17 days late. A quarterly MDS assessment for Resident 62, with an ARD of August 30, 2024, and the next quarterly MDS assessment with an ARD of December 4, 2024, was to be completed on December 1, 2024, which was three days late for an assessment to be completed every 92 days. An interview with Nursing Home Administrator on February 4, 2025, at 4:39 p.m. confirmed that the quarterly MDS assessments listed above were not completed within the required time frames. 28 Pa. Code 211.5(f) Clinical Records.	F 0638		

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F 0638 SS=E	Continued from page 6 28 Pa. Code 211.12(d)(5) Nursing Services.	F 0638		
F 0641 SS=B	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 63 significant change assessment, assessment reference date of 11/29/2024 was corrected and resubmitted to include the following medications: N0415B, N0415C, N0415E and N0415F. Resident 78 discharge assessment was corrected and resubmitted on 2/4/2025. 2. Any resident has potential to be affected by this deficient practice. 3. Staff have been reeducated on section N for medication listing and section A for discharge disposition. 4. Six random assessments a week will be audited times 4 weeks. These audits will verify that medications are properly coded and/or discharge disposition was correct. Audits will be submitted to Quality Assessment Team for review and to determine if audits should continue. Director of Nursing or designee will monitor.	Completion Date: **03/30/2025** Status: **APPROVED** Date: **03/03/2025**

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F 0641 SS=B	Continued from page 7 Based on a review of the Resident Assessment Instrument User's Manual and clinical records, as well as staff interviews, it was determined that the facility failed to complete accurate Minimum Data Set (MDS) assessments for two of 43 residents reviewed (Residents 63, 78). Findings include: The Long-Term Care Facility RAI User's Manual, which provides guidance and instructions for the completion of MDS assessments, dated October 2024, revealed that Section N was to be coded for medications received in the last seven days. Section N0415B was to be coded if the resident received an antianxiety medication in the previous seven days. N0415C was to be coded if the resident received an antidepressant medication in the last seven days. Section N0415E was to be coded if the resident received an anticoagulant (blood thinner) in the last seven days. Section N0415F was to be coded in the resident received an antibiotic in the last seven	F 0641		

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F 0641 SS=B	Continued from page 8 days. Physician's orders for Resident 63, dated October 24, 2024, included an order for the resident to receive 0.5 milligrams (mg) Lorazepam (anti-anxiety medication) three times a day and an order for the resident to receive 60 mg Duloxetine (antidepressant) daily. Physician's order, dated October 23, 2024, included an order for the resident to receive 2.5 mg Apixaban (anticoagulant) two times a day and an order for the resident to receive 250 mg Cephalexin (antibiotic) daily for seven days. A significant change MDS assessment for Resident 63, dated October 29, 2024, revealed that Section N0415B was coded indicating that the resident had not received an anti-anxiety medication, Section N0415C was coded indicating that the resident had not received an antidepressant, Section N0415E was coded indicating that the resident had not received an anticoagulant, and Section N0415F was coded indicating that the resident had not received	F 0641		

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F 0641 SS=B	Continued from page 9 an antibiotic. Interview with the Nursing Home Administrator on February 5, 2025 at 10:53 a.m. revealed that Resident 63's MDS assessment was coded incorrectly. The Long-Term Care Facility RAI User's Manual, dated October 2024, revealed that Section A2105 was to be coded based on the discharge status of the resident. A Discharge Return Not Anticipated MDS assessment, dated November 11, 2024, for Resident 78 indicated that the resident was discharged to the hospital. A nursing note for Resident 78, dated November 11, 2024, indicated that the resident was discharged home with his brother. Interview with the Nursing Home Administrator on February 4, 2025, at 3:38 p.m. revealed that	F 0641		

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F 0641 SS=B	Continued from page 10 Resident 78's MDS assessment was coded incorrectly. 28 Pa. Code 211.5(f) Clinical Records.	F 0641		
F 0656 SS=D	483.21(b)(1)(3) Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the	F 0656	1. Residents 37 and 293 have been discharged from the facility. 2. Any newly admitted resident has the potential to have an incorrect care plan. 3. The clinical team will review new admissions, including the initial care plan the next business day after admission to ensure no medications are missed on the admission care plan. Clinical team has been educated on this altered process. 4. Random audits of new admissions will be done weekly x 4 and then monthly x2 to ensure that medications are included in the initial care plan. These audits will be reported to the Quality Assurance team for review. Director of Nursing or designee will monitor.	Completion Date: **03/30/2025** Status: **APPROVED** Date: **03/03/2025**

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F 0656 SS=D	Continued from page 11 resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by:	F 0656		

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F 0656 SS=D	Continued from page 12 Based on review of facility policy and clinical records, as well as staff interviews, it was determined that the facility failed to develop comprehensive care plans that included specific and individualized treatment for two of 43 residents reviewed (Residents 37, 293) who were receiving intravenous antibiotics and anticoagulants. Findings include: A facility policy for care plans, dated January 15, 2024, revealed that the care plan is based on the resident's comprehensive assessment. Admission orders for Resident 37, dated December 18, 2024, included an order for the resident to receive 10 milligrams (mg) normal saline to flush the peripherally inserted central catheter or PICC line (a thin flexible tube inserted into a vein in the upper arm for fluid or medication administration), and for the resident to receive 1.5 grams Vancomycin (antibiotic) every 24 hours for a left hip infection.	F 0656		

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F 0656 SS=D	Continued from page 13 Observations of Resident 37 on February 3, 2025, at 1:03 p.m. revealed that the resident had a PICC line in her right upper extremity. Resident 37's Medication Administration Record (MAR) for December 2024 and January 2025 revealed that the resident received the Vancomycin through her PICC line every 24 hours and IV flushes for her PICC line daily after the Vancomycin. There was no documented evidence that Resident 37's care plan included a PICC line or antibiotic medication. Interview with the Assistant Director of Nursing on February 5, 2025, at 12:12 p.m. confirmed that Resident 37's care plan was not individualized regarding the resident's PICC line and Vancomycin and it should have been.	F 0656		

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F 0656 SS=D	Continued from page 14 Admission orders for Resident 293, dated January 21, 2025, included an order for the resident to receive 15 milligrams (mg) of Xarelto (anticoagulant) by mouth daily. A review of Resident 293's MAR, dated January and February 2025, revealed that the resident received the Xarelto daily. There was no documented evidence that Resident 293's care plan included the resident's anticoagulant medication. Interview with the Assistant Director of Nursing on February 4, 2025, at 12:01 p.m. confirmed that Resident 239's care plan was not individualized regarding the resident's Xarelto and that it should have been. 28 Pa. Code 201.24(e)(4) Admission Policy.	F 0656		
F 0684 SS=D		F 0684		

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F 0684 SS=D	Continued from page 15 483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by:	F 0684	1. Resident 41 meds were reviewed for accuracy. 2. A house audit was conducted to review and reconcile resident medications for discontinued discrepancies. None were found. 3. The process was changed, and nurses were educated so that the person taking the discontinued order goes to the cart and removes the discontinued medication. During clinical review each morning a list of discontinued medications will be reviewed and given to the RN supervisor to verify accuracy of cart medications. 4. An audit of discontinued medications against cart accuracy will be done weekly x 4 and then monthly x2 and reported to Quality Assurance team for review. Director of Nursing or designee will monitor.	Completion Date: **03/30/2025** Status: **APPROVED** Date: **03/03/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395778	A. BLDG: __00_____ B. WING: _____	02/05/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
COMMUNITIES AT INDIAN HAVEN, THE STATE LICENSE NUMBER: **090102**	**1675 SALTSBURG AVENUE INDIANA, PA 15701**

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F 0684 SS=D	Continued from page 16 Based on clinical record reviews and staff interviews, it was determined that the facility failed to provide medications as ordered by the physician for one of 43 residents reviewed (Resident 41). Findings include: A quarterly MDS assessment for Resident 41, dated December 19, 2024, revealed that the resident was cognitively intact, required moderate assistance from staff for daily care, and had diagnoses that included high blood pressure. Physician's orders for Resident 41, dated February 4, 2025, revealed that the resident was to stop taking 5 milligrams (mg) amlodipine (a medication to treat high blood pressure) and to start taking 5 mg of lisinopril (a medication to treat high blood pressure). Observations of Licensed Practical Nurse 1 during medication administration on February 5, 2025, at 8:00 a.m. revealed that she dropped a 5 mg tablet	F 0684		

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F 0684 SS=D	Continued from page 17 of amlodipine on the cart, picked it up with her bare hands, and administered the pill to Resident 41. Interview with Licensed Practical Nurse 1 at that time confirmed that she administered 5 mg of amlodipine and not 5 mg of lisinopril as ordered. She also confirmed that should not have touched the 5 mg tablet of amlodipine with her bare hands. A nurse's note for Resident 41, dated February 5, 2025, at 2:01 p.m., revealed that the Medical Director was notified that the resident received 5 mg of amlodipine and did not receive 5 mg of lisinopril as ordered. New orders were received from the Medical Director to hold the lisinopril for one day. Interview with the Nursing Home Administrator on February 5, 2025, at 10:07 a.m. indicated that she was told the 5 mg of amlodipine had not been given to Resident 41. She also confirmed that medications should not be touched with bare hands. 28 Pa. Code 211.12(d)(5) Nursing Services.	F 0684		

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F 0770 SS=D	483.50(a)(1)(i) Laboratory Services §483.50(a) Laboratory Services. §483.50(a)(1) The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. (i) If the facility provides its own laboratory services, the services must meet the applicable requirements for laboratories specified in part 493 of this chapter. This REQUIREMENT is not met as evidenced by:	F 0770	1. Resident 37 has been discharged home. 2. A house audit was conducted to review labs ordered and the last draw date to ensure compliance. 3. The lab procurement process was simplified and streamlined to ensure labs have less chance of being missed. Nurses were educated on the revised process. A report will be run each evening for the next day's labs. Clinical team will review in morning meeting for accuracy. 4. An audit of ordered labs will be done weekly x 4 and then monthly x2 and reported to the Quality Assurance team for review. Director of Nursing or designee will monitor.	Completion Date: **03/30/2025** Status: **APPROVED** Date: **03/03/2025**

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 0770 SS=D	Continued from page 19 Based on review of facility policy and clinical records, as well as staff interviews, it was determined that the facility failed to ensure that laboratory specimens were obtained as ordered by the physician for one of 43 residents reviewed (Resident 37). Findings include: A facility policy for lab and diagnostic testing, dated January 15, 2024, revealed that the physician will order diagnostic testing and the staff will process test requisitions and arrange for tests. Physician's orders for Resident 37, dated January 21, 2025, included an order for the resident to have a vancomycin (antibiotic) trough (a blood test to monitor the therapeutic dose of vancomycin) 30 minutes prior to vancomycin administration on January 24, 2025. A nursing note for Resident 37, dated January 25, 2025, at 1:15 p.m. revealed that the vancomycin trough was missed on January 25,	F 0770		

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 0770 SS=D	Continued from page 20 2025. New orders were received by the physician to have the vancomycin trough drawn 30 minutes prior to vancomycin administration on January 25, 2025. Interview with the Nursing Home Administrator on February 5, 2025, at 10:52 p.m. confirmed that a vancomycin trough was not obtained per physician order on January 24, 2025. 28 Pa. Code 211.12(d)(3) Nursing Services.	F 0770		
F 0803 SS=E		F 0803		

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F 0803 SS=E	Continued from page 21 483.60(c)(1)-(7) Menus Meet Resident Nds/Prep in Adv/Followed §483.60(c) Menus and nutritional adequacy. Menus must- §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; §483.60(c)(2) Be prepared in advance; §483.60(c)(3) Be followed; §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups; §483.60(c)(5) Be updated periodically; §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. This REQUIREMENT is not met as evidenced by:	F 0803	1. No individual resident was named or harmed. 2. No residents were harmed by substituting a nutritionally equivalent bread type for lunch. Any resident has potential to be harmed by menu substitution. 3. Re-education of the individual cook and other cooks regarding the menu substitution policy and procedure has been given by the kitchen operator. 4. Random tray audits will be conducted weekly x 4 and then monthly x2 to ensure that meal is served as posted. These audits will be reported to the Quality Assurance team for review. Dietary manager to monitor.	Completion Date: **03/30/2025** Status: **APPROVED** Date: **03/03/2025**

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 0803 SS=E	Continued from page 22	F 0803		

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 0803 SS=E	Continued from page 23 Based on a review of facility policies and written menus, as well as observations and staff and resident interviews, it was determined that the facility failed to follow their planned menu. Findings include: A facility policy, dated January 15, 2024, indicated that food menu substitutions for unplanned situations, such as an emergency event, food unavailability, or special dining events, would be communicated to residents prior to meal service. The facility's written and printed menu for the dinner meal on February 4, 2025, indicated that the residents were to receive vegetable soup, chicken salad croissant, roasted vegetables, and sliced peaches. Observations of the lunch meal in the dining room on February 4, 2025, at 5:00 p.m. revealed that the facility served chicken salad on a hamburger bun	F 0803		

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F 0803 SS=E	Continued from page 24 and not a croissant as listed on the menu. Interview with Dietary Aide 2 on February 4, 2025, at 5:22 p.m. confirmed that staff made a mistake, and that the Dietary Manager was to update staff and residents. Interview with the Resident 51, who was the resident council president, on February 4, 2025, at 5:38 p.m. indicated that he was not informed of the menu change. Interview with the Nursing Home Administrator on February 5, 2025, at 9:36 a.m. confirmed that a hamburger bun was substituted for the croissant for the dinner meal on February 4, 2025, and that the residents were not informed of the change prior to the meal.	F 0803		
F 0842 SS=D		F 0842		

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F 0842 SS=D	Continued from page 25 483.20(f)(5), 483.70(h)(1)-(5) Resident Records - Identifiable Information §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(h) Medical records. §483.70(h)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(h)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;	F 0842	1. Resident 37 has been discharged home. 2. Any resident has the potential to be affected by this deficient practice. 3. The process for reviewing medications was amplified and nurses were educated. At the end of each shift, the nurse will review the medication administration record for any medications not given, and document after administration. If not given, a note of explanation will be placed in chart and physician notified as needed. Each morning the Director of Nursing or designated supervisor will run a list of missed medications from the previous day and rectify per procedure. 4. An audit of missed medications will be done weekly x 4 and then monthly x2 and reported to the Quality Assurance team for review. Director of Nursing or designee will monitor.	Completion Date: **03/30/2025** Status: **APPROVED** Date: **03/03/2025**

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F 0842 SS=D	Continued from page 26 (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(h)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(h)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.	F 0842		

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F 0842 SS=D	Continued from page 27 This REQUIREMENT is not met as evidenced by:	F 0842		

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F 0842 SS=D	Continued from page 28 Based on review of facility policies and clinical records, as well as staff interviews, it was determined that the facility failed to ensure that clinical records were complete and accurately documented for one of 43 residents reviewed (Resident 37). Findings include: The facility's policy for medication administration, dated January 15, 2024, revealed that the facility shall maintain a medication administration record to document all medications administered. An admission Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 37, dated December 17, 2024, revealed that she was cognitively intact and required partial staff assistance with her daily care needs. Physician's orders for Resident 37, dated December	F 0842		

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F 0842 SS=D	Continued from page 29 17, 2024, included orders for the resident to receive 1.5 grams of vancomycin HCL in dextrose intravenous solution 1.5-5 grams/300 ml (an antibiotic) every 24 hours; 10 milliliters (ml) of normal saline solution (NSS) intravenously after receiving her antibiotic; 5 ml of Heparin Porcine (an anticoagulant) intravenously after the second NSS flush in the afternoon; 25 micrograms (mcg) of levothyroxine sodium (a thyroid hormone) once a day; 300 mg lithium carbonate (a medication used to treat mood disorders) in the evening; 20 mg omeprazole (a medication used to treat acid reflux) at 6:00 a.m. daily; and 5 mg of olanzapine (an antipsychotic) in the evening. There was no documented evidence in Resident 37's Medication Administration Records (MAR) for December 2024, January 2025, and February 2025 that the resident received the 1.5 grams of vancomycin HCL in dextrose intravenous solution 1.5-5 grams/300 ml on December 25 and 30, 2024, and January 29, 2025; the NSS flushes on December 25 and 30, 2024; the Heparin Porcine	F 0842		

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F 0842 SS=D	Continued from page 30 on December 21, 25, and 30, 2024, and January 7, 23, and 29, 2025; the 25 mcg of levothyroxine sodium as ordered on December 19, 23, and 25, 2024 and January 4, 8, and 30, 2025; the 300 mg of lithium carbonate and 5 mg of olanzapine on January 7, 2025; or the 20 mg omeprazole on January 4, 8, and 30, 2025. An interview with Resident 37 on February 5, 2025, at 12:01 p.m. confirmed that she has not missed any medications since arriving at the facility. An interview with the Nursing Home Administrator on February 5, 2025, at 11:40 a.m. confirmed that Resident 37's clinical record was not complete and accurately documented on the dates listed above. 28 Pa. Code 211.5(f) Clinical Records. 28 Pa. Code 211.12(d)(5) Nursing Services.	F 0842		
F 0867 SS=D		F 0867		

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COMMUNITIES AT INDIAN HAVEN, THE STATE LICENSE NUMBER: **090102**	**1675 SALTSBURG AVENUE INDIANA, PA 15701**

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F 0867 SS=D	Continued from page 31 483.75(c)(d)(e)(g)(2)(i)(ii) QAPI/QAA Improvement Activities §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.71 and including how such information will be used to develop and monitor performance indicators. §483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation. §483.75(c)(4) Facility adverse event monitoring, including	F 0867	1. No individual resident was named or harmed. 2. Any resident has potential to be harmed by failure to correct systems in the facility. 3. Re-evaluation of the Quality Assurance process has resulted in a reorganization of the current Performance Improvement Plans. Regular quarterly meeting in February finalized new Performance Improvement Plans to be monitored and reevaluated in 3 months. 4. Administrator to monitor for compliance.	Completion Date: **03/30/2025** Status: **APPROVED** Date: **03/03/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395778	A. BLDG: __00_____ B. WING: _____	02/05/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
COMMUNITIES AT INDIAN HAVEN, THE STATE LICENSE NUMBER: **090102**	**1675 SALTSBURG AVENUE INDIANA, PA 15701**

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F 0867 SS=D	Continued from page 32 the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events. §483.75(d) Program systematic analysis and systemic action. §483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained. §483.75(d)(2) The facility will develop and implement policies addressing: (i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems; (ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and (iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained. §483.75(e) Program activities. §483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the	F 0867		

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F 0867 SS=D	Continued from page 33 incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care. §483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility. §483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.71. Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section. §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must:	F 0867		

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F 0867 SS=D	Continued from page 34 (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by:	F 0867		

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COMMUNITIES AT INDIAN HAVEN, THE	**1675 SALTSBURG AVENUE INDIANA, PA 15701**
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F 0867 SS=D	Continued from page 35 Based on review of the facility's plans of correction for previous surveys, and the results of the current survey, it was determined that the facility's Quality Assurance Performance Improvement (QAPI) committee failed to correct quality deficiencies and ensure that plans to improve the delivery of care and services effectively addressed recurring deficiencies. Findings include: The facility's deficiencies and plans of corrections for a State Survey and Certification (Department of Health) survey ending March 21, 2024, and October 2, 2024, revealed that the facility developed plans of correction that included quality assurance systems to ensure that the facility maintained compliance with cited nursing home regulations. The results of the current survey, ending January 24, 2025, identified repeated deficiencies related to timely quarterly MDS assessments, accurate MDS assessments, comprehensive care plans, and quality of care.	F 0867		

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 0867 SS=D	Continued from page 36 The facility's plan of correction for a deficiency regarding a failure to provide quarterly assessments at least every three months, cited during the survey ending March 21, 2024, and October 2, 2024, revealed that the facility developed a plan of correction that included completing audits and reporting the results of the audits to the QAPI committee for review. The results of the current survey, cited under F638, revealed that the facility's QAPI committee failed to successfully implement their plan to ensure ongoing compliance with regulations regarding quarterly assessments at least every three months. The facility's plan of correction for a deficiency regarding a failure to provide accurate resident assessments, cited during the survey ending March 21, 2024, revealed that the facility developed a plan of correction that included completing audits and reporting the results of the audits to the QAPI committee for review. The results of the current survey, cited under F641, revealed that the facility's QAPI committee failed to successfully implement	F 0867		

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F 0867 SS=D	Continued from page 37 their plan to ensure ongoing compliance with regulations regarding accuracy of assessments. The facility's plan of correction for a deficiency regarding a failure to provide comprehensive resident care plans, cited during the survey ending March 21, 2024, and October 2, 2024, revealed that the facility developed a plan of correction that included completing audits and reporting the results of the audits to the QAPI committee for review. The results of the current survey, cited under F656, revealed that the facility's QAPI committee failed to successfully implement their plan to ensure ongoing compliance with regulations regarding comprehensive resident care plans. The facility's plan of correction for a deficiency regarding a failure to provide quality of care, cited during the survey ending March 21, 2024, revealed that the facility developed a plan of correction that included completing audits and reporting the results of the audits to the QAPI committee for review. The results of the current survey, cited under F684,	F 0867		

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F 0867 SS=D	Continued from page 38 revealed that the facility's QAPI committee failed to successfully implement their plan to ensure ongoing compliance with regulations regarding quality of care. Refer to F638, F641, F656, F684. 28 Pa. Code 201.14(a) Responsibility of Licensee. 28 Pa. Code 201.18(e)(1) Management.	F 0867		
F 0880 SS=D		F 0880		

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F 0880 SS=D	Continued from page 39 483.80(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	1. Resident 41 was assessed and no harm suffered from ingesting the touched pill. 2. Any resident has the potential to be affected by this deficient practice. 3. Nurses have been re-educated on the policy of not touching medication with bare hands. Three nurses will be observed each week doing a medication pass for one resident each. This audit will be done weekly x 4 and then monthly x2 and reported to the Quality Assurance team for review. Director of Nursing or designee will monitor	Completion Date: **03/30/2025** Status: **APPROVED** Date: **03/03/2025**

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F 0880 SS=D	Continued from page 40 (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		

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F 0880 SS=D	Continued from page 41	F 0880		

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F 0880 SS=D	Continued from page 42 Based on clinical record reviews, observations, and staff interviews, it was determined that the facility failed to ensure that proper infection control practices were followed while administering medications for one of 43 residents reviewed (Resident 41). Findings include: Physician's orders for Resident 41 included orders for the resident to receive 5 mg amlodipine (a medication that is used to treat high blood pressure) that was discontinued on February 4, 2025. Observations of Licensed Practical Nurse 1 during medication administration on February 5, 2025, at 8:00 a.m. revealed that she dropped a 5 mg tablet of amlodipine on the cart and picked it up with her bare hands, then administered the pill to Resident 41. Interview with Licensed Practical Nurse 1 at that time confirmed that she should not have touched the 5 mg tablet of amlodipine with her bare hands	F 0880		

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F 0880 SS=D	Continued from page 43 and administered it to the resident. Interview with the Nursing Home Administrator on February 5, 2025, at 10:07 a.m. confirmed that staff were not to touch residents' medications with their bare hands. 28 Pa. Code 211.12(d)(1)(5) Nursing Services.	F 0880		

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P 5520	Nursing services. (3) Effective July 1, 2024, a minimum of 1 nurse aide per 10 residents during the day, 1 nurse aide per 11 residents during the evening, and 1 nurse aide per 15 residents overnight. This REGULATION is not met as evidenced by:	P 5520	1. No individual resident was named or harmed. 2. Any resident has potential to be harmed by failure to have adequate staffing. 3. Facility has contracted with temporary agencies to fill upcoming vacancies. In the case of call-offs there is not often adequate time to find another coverage. Two upcoming nurse aide training classes will yield newly trained aides to fill vacancies on a permanent basis. Facility continues to advertise openings and opportunities. 4. Review of the daily schedule with nursing administration and Administrator continue. Weekly audits to ensure compliance of staffing ratios will be done x 4 weeks, then monthly x 2. Reviews submitted to the Quality Assurance team for review. Administrator to monitor for compliance.	Completion Date: **03/30/2025** Status: **APPROVED** Date: **03/03/2025**

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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P 5520	Continued from page 1 Based on a review of nursing schedules, staffing information furnished by the facility, and staff interview, it was determined that the facility failed to ensure a minimum of one nurse aide (NA) per 10 residents on the day shift for one of 21 days; and failed to ensure a minimum of one NA per 11 residents on the evening shift for one of 21 days; and failed to ensure a minimum of one NA per 15 residents on the overnight shifts for two of seven days reviewed for November 23 through 29, 2024; December 5 through 11, 2024; and January 30 through February 5, 2025. Findings include: Review of facility census data indicated that on November 28, 2024, the facility census was 75, which required 7.50 NA's during the day shift. Review of the nursing time schedules revealed 7.03 NA's provided care on the day shift on November 28, 2024.	P 5520		

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P 5520	Continued from page 2 Review of facility census data indicated that on November 29, 2024, the facility census was 75, which required 6.82 NA's during the evening shift. Review of the nursing time schedules revealed 5.83 NA's provided care on the evening shift on November 29, 2024. Review of facility census data indicated that on November 29, 2024, the facility census was 75, which required 5.00 NA's during the overnight shift. Review of the nursing time schedules revealed 4.40 NA's provided care on the overnight shift on November 29, 2024. On December 8, 2024, the facility census was 79, which required 5.27 NA's during the overnight shift. Review of the nursing time schedules revealed 4.60 NA's provided care on the overnight shift on December 8, 2024. On February 2, 2025, the facility census was 75, which required 5.07 NA's during the overnight shift. Review of the nursing time schedules revealed 4.90	P 5520		

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P 5520	Continued from page 3 NA's provided care on the overnight shift on February 2, 2025. No additional excess higher-level staff were available to compensate for these deficiencies. Interview with the Nursing Home Administrator on February 6, 2025, at 11:10 a.m. confirmed that the facility did not meet the required NA-to-resident staffing ratios for the days listed above.	P 5520		
P 5640		P 5640		

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NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
COMMUNITIES AT INDIAN HAVEN, THE STATE LICENSE NUMBER: **090102**	**1675 SALTSBURG AVENUE INDIANA, PA 15701**

(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
P 5640	Continued from page 4 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. No individual resident was named or harmed. 2. Any resident has potential to be harmed by failure to have adequate staffing. 3. Facility has contracted with temporary agencies to fill upcoming vacancies. In the case of call-offs there is not often adequate time to find another coverage. Two upcoming nurse aide training classes will yield newly trained aides to fill vacancies on a permanent basis. Facility continues to advertise openings and opportunities. 4. Review of the daily schedule with Nursing Administration and Administrator continue. Weekly audits to ensure compliance with required direct resident care hours will be done x 4 weeks, then monthly x 2. Reviews submitted to Quality Assurance team for review. Administrator to monitor for compliance.	Completion Date: **03/30/2025** Status: **APPROVED** Date: **03/03/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395778	A. BLDG: 00 B. WING:	02/05/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
COMMUNITIES AT INDIAN HAVEN, THE STATE LICENSE NUMBER: 090102	1675 SALTSBURG AVENUE INDIANA, PA 15701

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P 5640	Continued from page 5 Based on review of staffing information furnished by the facility and staff interviews, it was determined that the facility failed to provide 3.20 hours of direct resident care for each resident for one of 21 days (24-hour periods) reviewed. Findings include: Nursing time schedules provided by the facility for the days of November 23 through 29, 2024; December 5 through 11, 2024; and January 30 through February 5, 2025, revealed that the facility provided only 3.11 hours of direct care for each resident on November 29, 2024. Interview with the Nursing Home Administrator on February 6, 2025, at 11:10 a.m. confirmed that the facility did not meet the required daily direct resident care hours on the day listed above.	P 5640		

Certified End Page

COMMUNITIES AT INDIAN HAVEN, THE

STATE LICENSE NUMBER: 090102

SURVEY EXIT DATE: 02/05/2025

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