STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395828	A. BLDG: 00 B. WING:	01/30/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
MAPLE HEIGHTS HEALTH & REHAB CENTER STATE LICENSE NUMBER: **030202**	**429 MANOR DRIVE** **EBENSBURG, PA 15931**

(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 Civil Rights Compliance survey completed on January 30, 2025, it was determined that Maple Heights Health and Rehab Center 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 0550 SS=D		F 0550		

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 0550 SS=D	Continued from page 1 483.10(a)(1)(2)(b)(1)(2) Resident Rights/Exercise of Rights §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.	F 0550	Preparation and submission of this Plan Of Correction (POC) is required by state and federal law. This Plan Of Correction (POC) does not constitute an admission for purposes of general liability, professional malpractice or any other court proceeding Resident #84 had facial hair removed at the time of the survey. To identify other residents with the potential to be affected, the Director of Nursing/designee will audit female residents to see if they have a preference on facial hair removal and will add it to their shower day order and plan of care. To prevent a future occurrence, the Director of Nursing/designee will educate nursing staff on the resident right policy/in-service as well as the importance of following female resident's preference on facial hair removal. To monitor and maintain ongoing	Completion Date: **03/17/2025** Status: **APPROVED** Date: **02/20/2025**

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F 0550 SS=D	Continued from page 2 §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by:	F 0550	compliance, the Director of Nursing/designee will complete an audit of 10 random female residents to ensure there is no facial hair present weekly x4 and then monthly x2. Results of audits will be forwarded to facility's Quality Assurance and Process Improvement committee for review upon completion for review and recommendations.	

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F 0550 SS=D	Continued from page 3 Based on clinical record reviews, observations, and staff interviews, it was determined that the facility failed to ensure that assistance with hygiene was given in a manner that maintained dignity for one of 66 residents reviewed (Resident 84). Findings include: A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 84, dated December 17, 2024, revealed that the resident was understood and could understand others. A care plan for the resident, dated January 20, 2025, revealed that the resident had an activity of daily living (ADL - refer to basic tasks necessary for self-care and independent living) self-care performance deficit and staff was to help with morning and evening care. The facility's bath schedule indicated that Resident 84 was to receive a shower during the evening shift on Tuesdays and Fridays. The resident's clinical	F 0550		

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F 0550 SS=D	Continued from page 4 record revealed that the resident refused the shower and accepted a bed bath on January 24, 2025. However, there was no documented evidence that staff had asked the resident and/or that the resident had refused to have her facial hair removed. Observations of Resident 84 on January 27, 2025, at 1:24 p.m. and on January 28, 2025, at 11:51 a.m. revealed that the resident was lying in bed and she had multiple visible hairs on her chin approximately one-half to three-quarters of an inch long. Interview with the Director of Nursing on January 29, 2025, at 8:29 a.m. revealed that she had the staff go back to Resident 84 during the evening shift on January 28, 2025, and the resident allowed the staff to shave her facial hair. She indicated that they do not have a policy regarding facial hair preferences for females. She indicated that staff are to ask at the time of their shower, and that it would depend on the resident's response at that time if the staff would or would not remove the facial hair.	F 0550		

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F 0550 SS=D	Continued from page 5 28 Pa. Code 211.12(d)(5) Nursing Services.	F 0550		
F 0552 SS=D		F 0552		

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F 0552 SS=D	Continued from page 6 483.10(c)(1)(4)(5) Right to be Informed/Make Treatment Decisions §483.10(c) Planning and Implementing Care. The resident has the right to be informed of, and participate in, his or her treatment, including: §483.10(c)(1) The right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition. §483.10(c)(4) The right to be informed, in advance, of the care to be furnished and the type of care giver or professional that will furnish care. §483.10(c)(5) The right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she prefers. This REQUIREMENT is not met as evidenced by:	F 0552	Preparation and submission of this Plan Of Correction (POC) is required by state and federal law. This Plan Of Correction (POC) does not constitute an admission for purposes of general liability, professional malpractice or any other court proceeding Facility could not go back and notify Resident #79 of a previous appointment. Facility clarified Resident #79 preference of notification at the time of the survey. To identify other residents with the potential to be affected, the Director of Nursing/designee will audit appointments for the previous month to see if notifications were made and documented. To prevent a future occurrence, the Director of Nursing/designee will educate nursing staff/transportation on the resident right to make informed choices and participate in his/her treatment.	Completion Date: **03/17/2025** Status: **APPROVED** Date: **02/20/2025**

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F 0552 SS=D	Continued from page 7	F 0552	To monitor and maintain ongoing compliance, the Director of Nursing/designee will complete an audit of 10 appointments (if applicable) to ensure notifications are completed and documented weekly x4 and then monthly x2. Results of audits will be forwarded to facility's Quality Assurance and Process Improvement committee for review upon completion for review and recommendations.	

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F 0552 SS=D	Continued from page 8 Based on review of residents' clinical records and facility's grievance/complaint logs, as well as staff interviews, it was determined that the facility failed to honor the resident's right to make informed choices and participate in his/her treatment for one of 66 residents reviewed (Resident 79). Findings include: A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 79, dated November 21, 2024, revealed that the resident was understood and could understand others. Physician's orders for Resident 79, dated November 14, 2024, included an order to inform the resident of his treatment plan. A concern form for Resident 79, dated September 4, 2024, revealed that the resident presented a concern that he is not being informed of when his appointments are, and he wants to know his appointments in advance. The results of the action	F 0552		

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F 0552 SS=D	Continued from page 9 that were taken after the investigation indicated that the resident would be given at least a week's notice. Interview with Resident 79 on January 27, 2025, at 11:46 a.m. revealed that he was sent out to a procedure last Thursday and was never notified prior to the person transporting him to the procedure showed up in his room. Nursing notes for Resident 79, dated January 16, 2025, at 8:00 a.m. revealed that the resident left at this time via power wheelchair. A nursing note, dated January 16, 2025, at 7:12 p.m., revealed that the resident went to a vascular appointment this morning and was awaiting transport back to facility. A nursing note, dated January 16, 2025, at 7:58 p.m., revealed that the resident returned from the hospital via stretcher after having his suprapubic catheter (a thin, flexible tube inserted into the bladder through a small incision in the lower abdomen to drain urine) reinserted. A nursing note for Resident 79, dated January 28,	F 0552		

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F 0552 SS=D	Continued from page 10 2025, revealed that the writer spoke with the resident's sister at this time and explained to her about an appointment he had on January 16, 2025, as well as informed her that he had an appointment this Thursday at 1:45 p.m. There was no documented evidence in Resident 79's clinical record to indicate that the resident was notified of his appointments on January 16 and January 30, 2025. Interview with Resident 79 on January 29, 2025, at 12:30 p.m. revealed that he was looking on his patient portal (online access to your medical records) for his physician and found out that he has an appointment for this coming Thursday and that he was never informed from the facility staff that he had this appointment. Interview with the Director of Nursing on January 30, 2025, at 11:10 a.m. confirmed that there was no documented evidence that Resident 79 was informed of the January 16 and 30, 2025,	F 0552		

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F 0552 SS=D	Continued from page 11 appointments. She indicated that she notified the resident's sister because she wanted to be notified. She indicated that she would have to check with the resident and the resident's sister again to see what they want regarding the notification process. 28 Pa. Code 201.29(a) Resident Rights.	F 0552		
F 0585 SS=D		F 0585		

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F 0585 SS=D	Continued from page 12 483.10(j)(1)-(4) Grievances §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance	F 0585	Preparation and submission of this Plan Of Correction (POC) is required by state and federal law. This POC does not constitute an admission for purposes of general liability, professional malpractice or any other court proceeding Resident #18 grievance was resolved and reviewed with the resident at the time of the survey. To identify other residents with the potential to be affected, the Social Service Department/designee will audit grievances for the month of January to ensure they were addressed and to resolve per policy. To prevent a future occurrence, the Director of Nursing/designee will educate department heads on the grievance policy. To monitor and maintain ongoing compliance, the Director of Nursing/designee will complete an audit of current grievances to ensure they are addressed and resolved	Completion Date: **03/17/2025** Status: **APPROVED** Date: **02/20/2025**

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F 0585 SS=D	Continued from page 13 can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the	F 0585	timely weekly x4 and then monthly x2. Results of audits will be forwarded to facility's Quality Assurance and Process Improvement committee for review upon completion for review and recommendations.	

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F 0585 SS=D	Continued from page 14 date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by:	F 0585		

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F 0585 SS=D	Continued from page 15 Based on review of policies, clinical records, and facility grievance forms, as well as resident and staff interviews, it was determined that the facility failed to make ongoing efforts to resolve the grievances of residents for one of 66 residents reviewed (Resident 18). Findings include: The facility's grievance policy, revised October 19, 2018, indicated that the facility's grievance review would be completed in a reasonable time frame consistent with the type of grievance, but in no event would the review exceed 30 days. If the Grievance Committee/Grievance Official determined that a resident rights violation had occurred, the violation was to be corrected within 10 days. Upon completion of the review, the Grievance Official would complete a written grievance decision that included the following: the date the grievance was received, a summary of the statement of the resident's grievance, the steps taken to investigate	F 0585		

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 0585 SS=D	Continued from page 16 the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns, a statement as to whether the grievance was confirmed or not confirmed, whether any corrective action was or would be taken, and if the corrective action was or would be taken, and a summary of the corrective action. If corrective actions would not be taken, then an explanation of why such action was not necessary. The Grievance Official would meet with the resident and inform the resident of the results of the investigation and how the resident's grievance was resolved or would be resolved, if applicable. A copy of the written grievance decision would be provided to the resident upon request. A quarterly Minimum Data Set (MDS) assessment (a federally-mandated assessment of a resident's abilities and care needs) for Resident 18, dated December 16, 2024, revealed that the resident could make her needs known, was cognitively intact, and required assistance from staff for care. An interview with Resident 18 on January 27, 2025,	F 0585		

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F 0585 SS=D	Continued from page 17 at 10:26 a.m. revealed that she filed a grievance on December 25, 2024 and did not hear anything about it. A grievance form for Resident 18, dated December 25, 2024, revealed that the resident had concerns about not receiving her gas pill and that she was still not washed up for the day. She asked a nurse aide and licensed practical nurse at 1:00 p.m. to help her, and after she called the desk, she was washed up by 3:00 p.m. by two unknown nurse aides. The grievance was assigned on January 7, 2025, and the results of the action taken was that nursing was to review medication changes with Resident 18. There was no documented evidence that the resident's complaint/grievance was thoroughly investigated, including interviews and/or written statements from the staff who worked during the shift in question, whether or not there was proper care provided at that time or not, and did not include a statement as to whether the grievance was confirmed or not confirmed. There was also no documented evidence regarding ongoing efforts to resolve	F 0585		

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F 0585 SS=D	Continued from page 18 Resident 18's concerns until January 28, 2025, when the Nursing Home Administrator met with Resident 18, and it was decided that he would review in the morning clinical meeting changes to Resident 18's care regarding medication changes, including pharmacy delivery of her medications that were changed, outstanding laboratory tests, and other pertinent care issues. The Nursing Home Administrator would confirm with nursing that Resident 18 was made aware of those changes and would follow up with Resident 18 weekly with room visits to see how the mentioned issues were being addressed and discuss any other needs or questions she may have. There was no documented evidence that Resident 18 signed that she was informed of the grievance resolution until January 29, 2025. Interview with the Nursing Home Administrator on January 29, 2025, at 12:44 p.m. confirmed that there was no documented evidence that ongoing efforts were made to resolve Resident 18's	F 0585		

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F 0585 SS=D	Continued from page 19 grievance from December 25, 2024, and that the resident was not informed of the resolution until January 29, 2025. 28 Pa. Code 201.29(i) Resident Rights.	F 0585		
F 0600 SS=E	483.12(a)(1) Free from Abuse and Neglect §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by:	F 0600	Past noncompliance: no plan of correction required.	Completion Date: **02/20/2025** Status: **APPROVED** Date: **02/20/2025**

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F 0600 SS=E	Continued from page 20 Based on review of facility policies, investigation reports, and clinical records, as well as staff interviews, it was determined that the facility failed to ensure that residents were free from abuse or neglect for three of 66 residents reviewed (Residents 58, 130, 134). This deficiency is being cited as past non-compliance. Findings include: The facility's policy regarding abuse, neglect, and exploitation, dated December 30, 2024, indicated that the facility will not tolerate abuse, neglect, mistreatment, exploitation of residents, or misappropriation of resident property by anyone. Abuse was defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. Abuse also includes the deprivation by an individual including a caretaker of goods or services that are necessary to attain or maintain physical, mental, and psychological well-being.	F 0600		

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F 0600 SS=E	Continued from page 21 Neglect was defined as the failure of the facility, its employees, or services providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 58, dated October 25, 2024, revealed that the resident was understood and could understand others, was dependent on staff for toileting needs, was occasionally incontinent of urine, and had a diagnosis of dementia. A nursing note for Resident 58, dated November 21, 2024, revealed that Licensed Practical Nurse 2 reported to Registered Nurse 1 that Resident 58 was crying and stated, "she pulled my call bell out." Licensed Practical Nurse 2 observed the call bell on the floor, plugged it back into the wall, and alerted the registered nurse. The resident reported to Registered Nurse 1 that she had her call bell on last night to use the bed pan, "the girl" came in, pulled	F 0600		

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F 0600 SS=E	Continued from page 22 her call bell out and left, shutting the door without assisting her to the bedpan. A witness statement from Licensed Practical Nurse 2, dated November 21, 2024, revealed that when she went into Resident 58's room at 8:30 a.m. to administer the resident's medication, she observed the resident crying. When she asked the resident what was wrong, Resident 58 stated "she pulled my call bell out." Licensed Practical Nurse 2 observed the call bell lying on the floor and immediately plugged it back into the wall and notified the registered nurse. The facility's investigation, completed on November 22, 2024, revealed that the nurse aide accused of abuse/neglect by Resident 58 was identified as Nurse Aide 3. The allegation of abuse/neglect made by Resident 58 of Nurse Aide 3 was substantiated and Nurse Aide 3 was terminated. An interview with the Director of Nursing on January 29, 2025, at 11:10 a.m. confirmed that	F 0600		

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F 0600 SS=E	Continued from page 23 Resident 58's allegation of abuse/neglect was substantiated. A quarterly MDS assessment for Resident 130, dated August 7, 2024, revealed that the resident was cognitively impaired, required extensive assistance for daily care needs, and had a diagnosis of severe dementia with anxiety. A care plan for Resident 130, dated May 31, 2024, revealed that the resident had physical and behavioral symptoms toward others and has tried to push and hit staff when attempting to redirect. The resident can become aggressive with other residents. Approach and interventions included maintaining a calm environment; promptly provide incontinence care after bowel movements; provide care, activities, and a daily schedule that resembles the resident's prior lifestyle; and remove the resident from other resident rooms and unsafe situations. Resident 130 is currently being followed by psychiatry services since June 12, 2024, for behavior, mood and medication management.	F 0600		

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F 0600 SS=E	Continued from page 24 A nursing note for Resident 130, dated October 21, 2024, at 4:50 p.m., revealed that Registered Nurse 5 was called to room 415, where Resident 28 resides. Resident 130 entered the room and flipped Resident 28's supper tray on her from the bedside table while she was seated in her wheelchair. Resident 28 picked up the tray and hit Resident 130 on the top of the head. The residents were immediately separated and assessed, and no injuries were noted. Resident 130 was placed on one-on-one observation. Resident representatives, providers, and local police were notified of the incident. Resident 130 had no recollection of the incident and was placed on 15-minute checks. A statement from Resident 28, dated October 21, 2024, revealed that "a lady came in my room while I was eating supper and said that I was with her man. I said something back to her and she threw food all over me. I tried to scare her out by using my tray, I hit her on the head, but not hard I just wanted to scare her."	F 0600		

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F 0600 SS=E	Continued from page 25 A statement from Registered Nurse 5, dated October 21, 2024, revealed that she was called to Resident 28's room by her roommate stating that "something is wrong." Upon entering the room Resident 28 was observed sitting in her wheelchair with food on her and holding her dietary tray over Resident 130's head. Resident 28 was hitting resident 130 on the head with the tray. Resident 130 was removed from the room and Resident 28 stated that Resident 130 came in to her room and flipped the tray on her and she was hitting her with the tray to scare her out of the room. A psychiatry note for Resident 130, dated October 22, 2024, revealed that the visit was an emergent televisit (a visit via telecommunication) requested by the facility after a resident-to-resident altercation. Resident 130's mood was improved but continues to have intermittent episodes of agitation. Medications were reviewed and changes were 0.5 mg Ativan three times a day for five days then 0.25 mg Ativan at bedtime for 5 days then discontinue, 5	F 0600		

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F 0600 SS=E	Continued from page 26 mg Hydroxyzine four times a day for 5 days then 10 mg Hydroxyzine four times a day, 5 mg Hydroxyzine 5 mg/0.1 ml gel topically every eight hours for 10 days. Resident to be followed up on October 25, 2024. An interview with the Director of Nursing on January 28, 2025, at 1:35 p.m. confirmed that the facility's investigation was completed on October 22, 2024, and resident-to-resident abuse was substantiated. A nursing note for Resident 130, dated October 25, 2024, at 2:15 p.m. revealed that Nurse Aide 6 was walking down the South shoe hall and when she turned the corner, she witnessed an altercation with Resident 130 and Resident 350. Resident 130 was wandering in the hall and was attempting to enter the room of Resident 350 when Resident 350 kicked her in the groin and leg. The residents were redirected away from each other and safety was maintained. An assessment was attempted on Resident 130 and she refused repeatedly. She was	F 0600		

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F 0600 SS=E	Continued from page 27 agitated and was yelling and swearing. She was uncooperative and unable to be redirected. There were no visible signs of trauma or injury. The provider was notified of the resident-to-resident altercation, increased behaviors, and altered mental status. The order to transfer Resident 130 to the hospital was given and family was agreeable. Resident 130 was admitted to the Behavioral Health Unit at the hospital. A nursing note for Resident 130, dated October 28, 2024, at 11:42 a.m. revealed that a hearing was held regarding a 302 petition (an involuntary commitment process to provide immediate emergency treatment for individuals experiencing a mental health crisis). An interview with the Director of Nursing on January 28, 2025, at 1:35 p.m. confirmed that the facility's investigation was completed on October 25, 2024, and the resident-to-resident abuse was substantiated. A quarterly MDS assessment for Resident 134,	F 0600		

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F 0600 SS=E	Continued from page 28 dated November 4, 2024, revealed that the resident was cognitively impaired, required assistance for daily care needs, and had a diagnoses of Rhabdomyolysis (the breakdown of muscle tissue) and Parkinsonism (a brain condition that causes slowed movements, stiffness and tremors). A care plan for Resident 134, dated June 10, 2024, revealed that the resident had physical behavioral symptoms toward others, hitting, kicking, pushing, scratching and abusing other sexually. Approach and interventions included avoiding over stimulation, noise, crowding and aggressive residents, avoid power struggles with resident, offer one-step instructions and allow resident time to process information, when resident becomes aggressive keep distance between resident and others, leg rests for wheelchair during transport only. When not in use leg rests were to be placed in the bag on the back of the wheelchair. Resident 134 was currently being followed by psychiatry services since June 12, 2024 for behavior, mood, and medication management.	F 0600		

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F 0600 SS=E	Continued from page 29 A nursing note for Resident 134, dated December 17, 2024, at 1:50 p.m., revealed that the resident was involved in a resident-to-resident altercation after an activity. Resident 134 was propelling in the hallway in his wheelchair and was trying to get past Resident 92. When Resident 92 stated, "hang on a minute," Resident 134 took the footrest off of his wheelchair and hit Resident 92 in the head with it. The residents were immediately separated and Resident 92 was assessed and was noted to have a small laceration on the top of his head. Resident 92 stated, "it's not a big deal." Resident 92 was also assessed by the nurse practitioner on the unit. Responsible parties and local police were notified of the incident. Resident 134 was interviewed by social services and revealed that he did remember hitting someone and he did it because the man was going to unlock the main line and shut off all the power to the building. Resident 134 was to be evaluated by psychology the following day. A statement from Nurse Aide 7, dated December 17, 2024, revealed that she was pushing Resident	F 0600		

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F 0600 SS=E	Continued from page 30 134 through a door that Resident 92 was holding open, and Resident 134 took the footrest off of his wheelchair and hit Resident 92 on the top of the when he bent over. A psychiatry note for Resident 134, dated December 18, 2024, revealed that the resident was involved in a resident -to-resident altercation and the facility requested a visit. The altercation appears to be a misunderstanding due to the resident's mentation. Resident 134 thought that the other resident was going to cause harm. No medication changes were made and staff was to monitor mood and behavior. An interview with the Director of Nursing on January 30, 2025, at 12:30 p.m. confirmed that the facility's investigation was completed on December 17, 2024, an that resident-to-resident abuse was substantiated. Following the incident/investigation on December	F 0600		

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F 0600 SS=E	Continued from page 31 17, 2024, the facility's corrective actions included: Nursing staff were educated on abuse and education was completed December 17, 2024. Audits to monitor and maintain ongoing compliance with abuse prevention were conducted weekly for four weeks then monthly for two months. The results of these audits will be brought to Quality Assurance Performance Improvement committee for further analysis and corrective actions if necessary. A review of the facility's corrective actions revealed that they were in compliance with F600 on December 18, 2024. Interview with the Director of Nursing on January 30, 2025, at 12:30 p.m. revealed staff education was completed and ongoing audits are to be discussed during the monthly Quality Assurance (QA) meeting.	F 0600		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395828	A. BLDG: __00_____ B. WING: _____	01/30/2025

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F 0600 SS=E	Continued from page 32 28 Pa. Code 201.14(a) Responsibility of Licensee. 28 Pa. Code 201.18(b)(1)(e)(1) Management. 28 Pa. Code 211.10(c)(d) Resident Care Policies. 28 Pa. Code 211.12(d)(1)(5) Nursing Services.	F 0600		
F 0623 SS=D		F 0623		

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 0623 SS=D	Continued from page 33 483.15(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	Preparation and submission of this POC is required by state and federal law. This Plan Of Correction (POC) does not constitute an admission for purposes of general liability, professional malpractice or any other court proceeding The facility could not go back and notify Resident #12, Resident #32, or Resident #84 of their immediate transfer/discharge from the facility in written notification. To identify other residents with the potential to be affected, the Director of Nursing/designee will audit residents who had an immediate transfer/discharge within the last two weeks to see if the written notification to responsible parties was completed. To prevent a future occurrence, the Director of Nursing/designee will educate nursing staff/social service department on the immediate transfer/discharge paperwork to ensure that families and responsible	Completion Date: **03/17/2025** Status: **APPROVED** Date: **02/20/2025**

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F 0623 SS=D	Continued from page 34 (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	parties moving forward are notified in writing of the transfer from the facility. To monitor and maintain ongoing compliance, the Director of Nursing/designee will complete an audit of weekly hospital transfers to ensure written notifications to responsible parties were completed weekly x4 and then monthly x2. Results of audits will be forwarded to facility's Quality Assurance and Process Improvement committee for review upon completion for review and recommendations.	

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F 0623 SS=D	Continued from page 35 (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=D	Continued from page 36 Based on clinical record reviews and staff interviews, it was determined that the facility failed to ensure that a written notice was provided to the resident's responsible party regarding the reason for transfer to the hospital for three of 66 residents reviewed (Residents 12, 32, 84). Findings include: A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 12, dated December 10, 2024, indicated that the resident was understood, could understand others, and was cognitively intact. A nursing note, dated November 2, 2024, at 11:50 a.m., revealed that Resident 12 was observed lying on her left side on the floor between her bed and wheelchair. The resident was confused, had a tremor to her right hand, and stated that she had pain in her lower extremities. She was observed to be hyperventilating, staring blankly into the corner of	F 0623		

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F 0623 SS=D	Continued from page 37 the room, and had a nonproductive, moist cough. The resident's responsible party was notified and requested she be transferred to the hospital. Interview with the Social Service Director on January 30, 2025, at 2:37 p.m. confirmed that there was no documented evidence that a written notice of Resident 12's transfer to the hospital was provided to the resident's responsible party regarding the reason for transfer to the hospital on November 2, 2024. An annual MDS assessment for Resident 32, dated December 2, 2024, revealed that the resident was understood and could understand others. Nursing notes for Resident 32, dated December 29, 2024, at 7:05 a.m. revealed that the resident was checked at the bedside at the request of a licensed practical nurse due to change in the resident's condition. The resident was lying in bed awake but disoriented. The resident was lethargic (feeling	F 0623		

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F 0623 SS=D	Continued from page 38 tired, sluggish, or lacking in energy) and nodding head to answer some questions. The physician was contacted and a order was obtained to send the resident to the emergency department for further evaluation. A nursing note at 11:59 a.m. revealed that the resident was admitted with a diagnosis of septic shock (a life-threatening condition that occurs when an infection spreads throughout the body and causes a dangerously low blood pressure). Nursing notes for Resident 32, dated January 9, 2025, at 12:51 a.m. revealed that the resident was requesting to go to the emergency department for a complaint of shortness of breath. Verbal orders were obtained from the physician to send resident to emergency department for further treatment and evaluation. A nursing note at 5:48 p.m. revealed that the resident was admitted with a diagnosis of shortness of breath. There was no documented evidence that a written notice of Resident 32's transfer to the hospital was provided to the resident's responsible party	F 0623		

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F 0623 SS=D	Continued from page 39 regarding the reason for transfer to the hospital on December 29, 2024, and on January 9, 2025. Interview with the Nursing Home Administrator on January 29, 2025, at 12:08 p.m. confirmed that there was no documented evidence that a written notice of Resident 32's transfers to the hospital was provided to the resident's responsible party regarding the reason for transfer to the hospital on December 29, 2024, and on January 9, 2025. A quarterly MDS assessment for Resident 84, dated December 17, 2024, revealed that the resident was understood and could understand others. A nursing note for Resident 84, dated January 16, 2025, revealed that a roommate's family member approached the nurses' station stating that this resident was on the floor. Upon entering the resident's room, the resident was observed on the floor next to the bed on her right side. Blood was noted on the resident's face, upper body, and floor	F 0623		

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F 0623 SS=D	Continued from page 40 next to the resident. A large laceration was noted above her left eyebrow. The left nostril was noted to have blood coming from it, and a large blood clot was noted. The resident was unable to state what she was doing prior to the fall. The Certified Registered Nurse Practitioner (CRNP - a registered nurse (RN) who has obtained advanced education and training allowing them to diagnose illnesses, prescribe medication, and provide patient care in a specialized area of healthcare) was updated, and orders were received to send the resident to the hospital for evaluation. A nursing note for Resident 84, dated January 17, 2025, revealed that the resident was admitted to the hospital at this time. There was no documented evidence that a written notice of Resident 84's transfer to the hospital was provided to the resident's responsible party regarding the reason for transfer to the hospital on January 16, 2025.	F 0623		

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F 0623 SS=D	Continued from page 41 Interview with the Director of Nursing on January 29, 2025, at 10:15 a.m. confirmed that there was no documented evidence that a written notice of Resident 84's transfers to the hospital was provided to the resident's responsible party regarding the reason for transfer to the hospital on January 16, 2025. 28 Pa. Code 201.14(a) Responsibility of Licensee.	F 0623		
F 0636 SS=D		F 0636		

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F 0636 SS=D	Continued from page 42 483.20(b)(1)(2)(i)(iii) Comprehensive Assessments & Timing §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning.	F 0636	Preparation and submission of this Plan of Correction (POC) is required by state and federal law. This POC does not constitute an admission for purposes of general liability, professional malpractice or any other court proceeding Resident #141 will have a timely Minimum Data Set (MDS) assessment completed. Resident #143 will have a timely MDS assessment completed. Resident #147 was discharged from the facility on 12/25/24. Resident #152 will have a timely MDS assessment completed. Resident #165 will have a timely MDS assessment completed. To identify other residents with the potential to be affected, the MDS nurse/designee will audit current residents and new admissions for the last 30 days to ensure	Completion Date: **03/17/2025** Status: **APPROVED** Date: **02/20/2025**

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F 0636 SS=D	Continued from page 43 (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts. §483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. This REQUIREMENT is not met as evidenced by:	F 0636	assessments are not overdue. To prevent a future occurrence, the Nursing Home administrator/designee provided education to the MDS nurses on completion of MDS assessments in accordance with the assessment reference date. To monitor and maintain ongoing compliance, the MDS team/designee will complete an audit weekly x4 then monthly x2 to ensure MDS assessments are in accordance with the assessment reference date. Results of audits will be forwarded to facility's Quality Assurance and Process Improvement committee for review upon completion for review and recommendations.	

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F 0636 SS=D	Continued from page 44 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 comprehensive admission Minimum Data Set assessments were completed in the required time frame for five of 66 residents reviewed (Residents 141, 143, 147, 152, 165). 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 a resident's abilities and care needs), dated October 2023, indicated that an admission MDS assessment was to be completed no later than 14 days (admission date + 13 calendar days) following admission. A comprehensive admission MDS assessment for Resident 141, dated October 28, 2024, revealed	F 0636		

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F 0636 SS=D	Continued from page 45 that the resident was admitted to the facility on October 21, 2024, and the resident's admission MDS assessment was dated as completed on November 5, 2024, which was 16 days after admission. A comprehensive admission MDS assessment for Resident 143, dated November 13, 2024, revealed that the resident was admitted to the facility on November 7, 2024, and the resident's admission MDS assessment was dated as completed on November 26, 2024, which was 20 days after admission. A comprehensive admission MDS assessment for Resident 147, dated November 7, 2024, revealed that the resident was admitted to the facility on November 1, 2024, and the resident's admission MDS assessment was dated as completed on November 15, 2024, which was 15 days after admission. A comprehensive admission MDS assessment for	F 0636		

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F 0636 SS=D	Continued from page 46 Resident 152, dated November 25, 2024, revealed that the resident was admitted to the facility on November 19, 2024, and the resident's admission MDS assessment was dated as completed on December 4, 2024, which was 16 days after admission. A comprehensive admission MDS assessment for Resident 165, dated January 2, 2025, revealed that the resident was admitted to the facility on December 27, 2024, and the resident's admission MDS assessment was dated as completed on January 10, 2025, which was 15 days after admission. An interview with Nursing Home Administrator on January 30, 2025, at 3:10 p.m. confirmed that the admission MDS assessments listed above were not completed within the required time frames. 28 Pa. Code 211.5(f) Clinical Records.	F 0636		

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F 0641 SS=E		F 0641		

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F 0641 SS=E	Continued from page 48 483.20(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	Preparation and submission of this POC is required by state and federal law. This Plan of Correction (POC) does not constitute an admission for purposes of general liability, professional malpractice or any other court proceeding Resident #12 will have a corrected Minimum Data Set (MDS.) Resident #17 will have a corrected MDS. Resident #18 will have a corrected MDS. Resident #25 will have a corrected MDS. Resident #41 will have a corrected MDS. Resident #93 will have a corrected MDS. Resident #122 will have a corrected MDS.	Completion Date: **03/17/2025** Status: **APPROVED** Date: **02/20/2025**

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F 0641 SS=E	Continued from page 49	F 0641	To identify other residents with the potential to be affected, the MDS nurse/designee will audit the most recent MDS assessment of residents to ensure they are coded correctly. Modifications will be made as necessary. To prevent a future occurrence, the Nursing Home administrator/designee provided education to the MDS nurses on proper coding of the MDS items. To monitor and maintain ongoing compliance, the MDS team/designee will complete an audit weekly x4 then monthly x2 to ensure MDS assessments are being properly coded. Results of audits will be forwarded to facility's Quality Assurance and Process Improvement committee for review upon completion for review and recommendations.	

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F 0641 SS=E	Continued from page 50 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 assessments for seven of 66 residents reviewed (Residents 12, 17, 18, 25, 41, 93, 122). Findings include: The Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual, which provides guidance and instructions for the completion of MDS assessments, dated October 2024, indicated that the intent of Section N was to record the number of days, during the seven-day assessment period, that any type of injection, insulin, and/or select medications were received by the resident. Section N0415B was to be coded if the resident received an antianxiety medication during the seven-day assessment period, Section N0415G1 Diuretic Medications (medications that promote the excretion of urine by the kidneys) was to be coded	F 0641		

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F 0641 SS=E	Continued from page 51 if the resident took the medication during the seven-day assessment period, Section N0451H was to be coded if the resident received an opioid (narcotic) medication during the seven-day assessment period, and Section N0451K was to be coded if the resident received an anti-convulsant during the seven-day assessment period. Section O0100J2 was to be coded for residents who received hemodialysis services (mechanical cleansing of the blood for a person whose kidneys are not functioning normally) while a resident within a 14-day look-back period. Section O0250A (Influenza Vaccine) was to be coded (0) if the resident did not receive the influenza vaccine, and (1) if the resident did receive the influenza vaccine, Section O0250B was to be completed with the date the influenza vaccine was received, and Section O0250C was to be coded with the reason why the influenza vaccine was not received; (1) if the resident was not in the facility during the flu season; (2) if received outside the facility; (3) if not eligible; (4) if offered and declined; (5) if not offered; (6) inability to obtain influenza vaccine due to a declared	F 0641		

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F 0641 SS=E	Continued from page 52 shortage; and (9) none of the above. A quarterly MDS assessment for Resident 12, dated December 10, 2024, revealed that the resident was not offered the influenza vaccine. However, a nursing note, dated September 26, 2024, revealed that Resident 12 refused the influenza vaccine despite education. Physician's orders for Resident 17, dated June 10, 2024, included an order for the resident to receive 300 milligrams (mg) of gabapentin (anticonvulsant medication) twice a day for neuropathy (weakness, numbness, and pain from nerve damage, usually in the hands and feet). Medication Administration Records (MAR's) for Resident 17, dated December 2024, revealed that staff administered 300 mg of gabapentin twice a day from November 1 through 30, 2024. However, Section N0415K1 of Resident 17's quarterly MDS assessment, dated November 20, 2024, was coded to indicate that the resident did not receive an anti-convulsant medication during the seven-day assessment.	F 0641		

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F 0641 SS=E	Continued from page 53 Physician's orders for Resident 18, dated May 30, 2024, included an order for the resident to receive 2 mg of bumetanide (a diuretic medication) daily for lymphedema (chronic condition that causes swelling in the body's tissues, typically in the arms or legs) of the lower extremities. Medication Administration Records (MAR's) for Resident 18, dated December 2024, revealed that staff administered 2 mg of bumetanide daily from December 1 through 16, 2024. However, Section N0415G1 of Resident 18's quarterly MDS assessment, dated December 16, 2024, was coded to indicate that the resident did not receive a diuretic medication during the seven-day assessment. A care plan for Resident 25, dated January 3, 2025, revealed diagnoses that included kidney failure and required hemodialysis treatments three times a week. A nursing note for Resident 25, dated January 4, 2025, revealed that she was out of the facility for hemodialysis treatment. However, Section O0100J2 of Resident 25's admission MDS,	F 0641		

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F 0641 SS=E	Continued from page 54 dated January 6, 2025, revealed that the section was not checked, indicating that the resident did not receive dialysis treatments during the assessment's 14-day look-back period. Interview with the Licensed Practical Nurse Assessment Coordinator 4 on January 30, 2025, at 2:10 p.m. confirmed that Section O0100J2 of Resident 25's admission MDS assessment of January 6, 2025, should have been coded to reflect that the resident received hemodialysis treatments during the assessment period. Physician's orders for Resident 41, dated December 26, 2024, included an order for the resident to receive 5 milligrams (mg) diazepam (anti-anxiety medication) every day. Review of the MAR for Resident 41, for December 2024 and January 2025 revealed that the resident received 5 mg of diazepam daily as ordered. However, a quarterly MDS assessment for Resident 41, dated January 8, 2025, revealed that Section N0415B was coded to indicate that the resident had not received an	F 0641		

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F 0641 SS=E	Continued from page 55 anti-anxiety medication. An influenza declination form for Resident 93, dated September 26, 2024, indicated that the resident refused the influenza vaccine. A pneumococcal vaccine declination form for Resident 93, dated March 12, 2024, indicated that the resident refused the pneumococcal vaccine. However, a quarterly MDS assessment for Resident 93, dated November 28, 2024, revealed that Section O0250C was coded "5" indicating that the flu vaccine was not offered and Section O0300B was coded "3" indicating that the pneumococcal vaccine was not offered. Physician's orders for Resident 122, dated June 25, 2024, included orders for the resident to receive 50 mg Tramadol (opioid) every six hours as needed for pain. Physician's orders dated August 9, 2024, included an order for the resident to receive 75 mg Topiramate (anti-convulsant) at bedtime and 50 mg twice a day. Review of the October and November 2024 MAR for Resident 122 revealed that the	F 0641		

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F 0641 SS=E	Continued from page 56 resident received Tramadol and Topiramate during the assessment period. However, a quarterly MDS assessment for Resident 122, dated November 4, 2024, revealed that Sections N0415H and N0415K were coded to indicate that the resident had not received the opioid and the anti-convulsant. Interview with the Licensed Practical Nurse Assessment Coordinator 4 (LPNAC - a licensed practical nurse who assists the Registered Nurse Assessment Coordinator with the completion of MDS assessments) on January 30, 2025, at 11:35 a.m. confirmed that MDS assessments for Residents 12, 17, 18, 41, 93, and 122 were coded inaccurately. 28 Pa. Code 211.5(f) Clinical Records.	F 0641		
F 0655 SS=D		F 0655		

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F 0655 SS=D	Continued from page 57 483.21(a)(1)-(3) Baseline Care Plan §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to:	F 0655	Preparation and submission of this Plan of Correction (POC) is required by state and federal law. This POC does not constitute an admission for purposes of general liability, professional malpractice or any other court proceeding Resident #94 care plan was reviewed at the time of the survey by the interdisciplinary team and will be revised/updated as needed. To identify other residents with the potential to be affected, the Minimum Data Set (MDS) nurse/designee will audit new admissions over the last 30 days to ensure that a baseline care plan was generated within 48 hours of admission, and reflected instructions needed to provide effective care to the resident based on physician orders and resident preferences/goals. To prevent a future occurrence, the Director of Nursing/designee provided education to the MDS	Completion Date: **03/17/2025** Status: **APPROVED** Date: **02/20/2025**

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F 0655 SS=D	Continued from page 58 (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by:	F 0655	nurses on the baseline care plan policy. To monitor and maintain ongoing compliance, the Director of Nursing/designee will complete an audit weekly x4 then monthly x2 to ensure baseline care plans are generated within 48 hours of admission and include information regarding resident's immediate care needs. Results of audits will be forwarded to facility's Quality Assurance and Process Improvement committee for review upon completion for review and recommendations.	

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F 0655 SS=D	Continued from page 59 Based on a review of facility policies, clinical record reviews, and staff interviews, it was determined that the facility failed to ensure that a resident's baseline care plan included information regarding the resident's immediate care needs for one of 66 residents reviewed (Resident 94). Findings include: A facility policy for interim/baseline care plans, dated December 30, 2024, revealed that within 48 hours of admission, the facility will develop and implement an interim/baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident until a comprehensive assessment can be completed, leading to a comprehensive care plan. The base line care plan will be used until the comprehensive assessment and care plan is developed by the interdisciplinary team. The base line care plan will include the minimum healthcare information necessary to care for a resident.	F 0655		

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F 0655 SS=D	Continued from page 60 A nursing note for Resident 94, dated December 14, 2024, revealed that the resident was a new admission to the facility from the hospital; that the resident receives hemodialysis services (mechanical cleansing of the blood for a person whose kidneys are not functioning normally) three time per week on Tuesday, Thursday, and Saturday; and the resident has an arteriovenous (AV) fistula (a procedure that connects an artery to a vein in preparation for dialysis). Physician's orders for Resident 94, dated December 15, 2024, included orders for staff to check the AV fistula site daily for bleeding; notify provider as needed; if bleeding occurs from the AV fistula site, apply pressure and if bleeding does not stop, call 911, and notify provider; and to check for a bruit (an audible vascular sound associated with turbulent blood flow) and thrill (a palpable vibration or sensation felt on the skin overlying a blood vessel) to the resident's left upper arm AV fistula site.	F 0655		

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F 0655 SS=D	Continued from page 61 There was no documented evidence that a baseline care plan was developed for Resident 25's care and treatment needs related to hemodialysis. Interview with the Licensed Practical Nurse Assessment Coordinator 4 (LPNAC - a licensed practical nurse who assists the Registered Nurse Assessment Coordinator with the completion of MDS assessments) on January 30, 2025, at 2:16 p.m. confirmed that a baseline care plan was not developed for Resident 25's care and treatment needs related to hemodialysis. 28 Pa. Code 211.12(d)(1) Nursing Services.	F 0655		
F 0656 SS=D		F 0656		

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F 0656 SS=D	Continued from page 62 483.21(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 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	F 0656	Preparation and submission of this POC is required by state and federal law. This Plan if Correction (POC) does not constitute an admission for purposes of general liability, professional malpractice or any other court proceeding Resident #44 will have an anticonvulsant/seizure disorder care plan created. To identify other residents with the potential to be affected, the Director of Nursing/designee will review other residents on anticonvulsants and with a seizure disorder to ensure they have appropriate care plans in place. To prevent a future occurrence, the Director of Nursing/designee provided education to the interdisciplinary team on the comprehensive care planning policy. To monitor and maintain ongoing compliance, the Director of Nursing/designee will complete an	Completion Date: **03/17/2025** Status: **APPROVED** Date: **02/21/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395828	A. BLDG: __00_____ B. WING: _____	01/30/2025

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F 0656 SS=D	Continued from page 63 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	audit weekly x4 then monthly x2 to ensure comprehensive care plans are in place. Results of audits will be forwarded to facility's Quality Assurance and Process Improvement committee for review upon completion for review and recommendations	

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F 0656 SS=D	Continued from page 64 Based on review of policies and clinical records, as well as staff interviews, it was determined that the facility failed to develop and implement a comprehensive person-centered care plan for each resident that included specific and individualized interventions for one of 66 residents reviewed (Resident 44). Findings include: The facility's policy regarding care plans, dated December 30, 2024, revealed that the facility was to develop a comprehensive, person-centered care plan for each resident that included measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that were identified in the comprehensive assessments. The comprehensive care plan was to be reviewed and updated at least every 90 days by the interdisciplinary team, and in cases of significant changes in the resident's condition, the care plan was to be updated within seven days of the new full assessment.	F 0656		

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F 0656 SS=D	Continued from page 65 A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 44, dated November 20, 2024 revealed that the resident was cognitively impaired, received an anti-convulsant medication, and had diagnoses that included a seizure disorder. Physician's orders for Resident 44, dated November 14 and December 30, 2024, included orders for the resident to receive 500 milligrams (mg) of valproic acid (anticonvulsant) two times a day for seizures and 1500 mg of levetiracetam (anticonvulsant) twice a day for seizures. The Medication Administration Record (MAR) for January 2025 revealed that Resident 44 was receiving valproic acid and levetiracetam two times a day. Review of the resident's current care plan revealed that there was no documented evidence that a care plan was developed to address Resident 44's care needs related to receiving anticonvulsant	F 0656		

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F 0656 SS=D	Continued from page 66 medications or having a seizure disorder. Interview with the Director of Nursing on January 28, 2025, at 1:32 p.m. confirmed that Resident 44's care plan did not include the use of anticonvulsant medications or a seizure disorder and should have. 28 Pa. Code 211.12(d)(5) Nursing Services.	F 0656		
F 0657 SS=E		F 0657		

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F 0657 SS=E	Continued from page 67 483.21(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	Preparation and submission of this This Plan of Correction (POC) is required by state and federal law. This This Plan of Correction (POC) does not constitute an admission for purposes of general liability, professional malpractice or any other court proceeding Resident #2 careplan changes were completed and are accurate. Resident #25 careplan changes were completed and are accurate. Resident #41 careplan changes were completed and are accurate. Resident #64 careplan changes were completed and are accurate. Resident #79 careplan changes were completed and are accurate. Resident #106 careplan changes were completed and are accurate. Resident #130 careplan changes were completed and are accurate.	Completion Date: **03/17/2025** Status: **APPROVED** Date: **02/21/2025**

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F 0657 SS=E	Continued from page 68	F 0657	To identify other residents with the potential to be affected, the Director of Nursing/designee will review care plans to ensure any changes to code status, Enhanced Barrier Precautions, antibiotics, out of bed orders, hospice care and residents on diuretic medication within the last two weeks were reviewed/revised correctly on the care plan. To prevent a future occurrence, the Director of Nursing/designee provided education to the interdisciplinary team on the comprehensive care planning policy. To monitor and maintain ongoing compliance, the Director of Nursing/designee will complete an audit weekly x4 then monthly x2 to ensure any changes to orders are reflected on the care plan. Results of audits will be forwarded to facility's Quality Assurance and Process Improvement committee for review upon completion for review and recommendations.	

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 0657 SS=E	Continued from page 69 Based on review of policies and clinical records, as well as observations and staff interviews, it was determined that the facility failed to ensure that care plans were updated to reflect changes in residents' care needs for seven of 66 residents reviewed (Residents 2, 25, 41, 64, 79, 106, 130). Findings include: The facility's policy regarding care plans, dated December 30, 2024, revealed that the facility was to develop a comprehensive, person-centered care plan for each resident that included measurable objectives and timetables to meet the resident's medical, nursing, mental and psychosocial needs that were identified in the comprehensive assessments. The comprehensive care plan was to be reviewed and updated at least every 90 days by the interdisciplinary team, and in cases of significant changes in the resident's condition, the care plan was to be updated within seven days of the new full assessment.	F 0657		

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F 0657 SS=E	Continued from page 70 An annual Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 2, dated November 3, 2024, indicated that the resident was cognitively intact and that she required assistance from staff for her daily care needs. Physician's order for Resident 2, dated October 10, 2024, indicated that the resident was a Do Not Resuscitate (DNR - do not provide Cardio-Pulmonary Resuscitation - CPR). Resident 2's care plan, most recently updated November 3, 2024, revealed that the resident was a full code (wanted CPR). There was no documented evidence that Resident 2's care plan was updated to reflect her change in code status to reflect that she no longer wanted CPR. Interview with the Director of Nursing on January 28, 2025, at 1:35 p.m. confirmed that Resident 2's care plan was not updated to reflect the change in her code status and that it should have been.	F 0657		

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F 0657 SS=E	Continued from page 71 Physician's orders for Resident 25, dated December 31, 2024, included an order for the resident to be on Enhanced Barrier Precautions (EBP - a set of infection control measures that use personal protective equipment (PPE) to reduce the spread of multidrug-resistant organisms (MDROs). Observations of Resident 25's room on January 27, 2025, at 12:32 p.m. revealed that there was signage on the resident's door indicating that the resident was on contact isolation (a set of precautions that healthcare workers and visitors take to prevent the spread of germs from a patient to others) and droplet precautions (a set of guidelines for caring for patients with respiratory infections). As of January 30, 2025, there was no documented evidence that Resident 25's care plan was revised/updated to include the EBP/Contact/Droplet precautions. Interview with the Licensed Practical Nurse	F 0657		

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F 0657 SS=E	Continued from page 72 Assessment Coordinator 4 (LPNAC - a licensed practical nurse who assists the Registered Nurse Assessment Coordinator with the completion of MDS assessments) on January 30, 2025, at 2:16 p.m. confirmed that there was no documented evidence that Resident 25's care plan was revised/updated to include the EBP/Contact/Droplet precautions. A quarterly MDS assessment for Resident 41, dated January 8, 2025, indicated that the resident was cognitively intact and that she required assistance from staff with daily care needs. Physician's orders for Resident 41, dated October 26, 2024, included an order for the resident to receive 500 milligrams (mg) Levaquin (antibiotic) daily for five days, after which time the medication would be discontinued. Resident 41's care plan, dated January 8, 2025, revealed that the resident had an active infection and was medicated with an antibiotic.	F 0657		

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F 0657 SS=E	Continued from page 73 There was no documented evidence that Resident 41's care plan was updated to reflect the discontinuation of the antibiotic. Interview with the Director of Nursing on January 30, 2025, at 1:47 p.m. confirmed that Resident 41's care plan was not updated after the discontinuation of the antibiotic and it should have been. A quarterly MDS assessment for Resident 64, dated November 6, 2024, indicated that the resident was cognitively impaired, required assistance from staff with daily care needs, and had diagnosis that included dementia. Physician's orders for Resident 64, dated January 20, 2025, included an order for the resident to be out of bed to an evolution chair in upright position with pressure redistribution cushion and bilateral standard leg rests for transport and outside only. Resident 64's care plan, dated July 11, 2023, revealed that the resident was a fall risk and included an intervention, dated August 15, 2023, that the resident be out of bed in a wheelchair with an Equagel seat cushion (used to	F 0657		

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F 0657 SS=E	Continued from page 74 distribute weight across a seat evenly) with antisling (helps prevent sliding and provides support) under the Equagel cushion, Dycem (Non-slip material keeps objects from sliding or rolling) under and on top of the antisling, a Posey pad (designed to alert caregivers when a fall-risk patient attempts to get up from a chair unassisted) on the back rest with lumbar (lower back) support behind the Posey pad, and lamb's wool on the armrests and leg rests for transport only. There was no documented evidence that Resident 64's care plan was updated to reflect that the resident was to be in an evolution chair as ordered. Interview with the Director of Nursing on January 29, 2025, at 11:10 a.m. confirmed that Resident 64's care plan was not updated when her out-of-bed to chair orders were changed. Physician's orders for Resident 79, dated December 29, 2024, included an order for the resident to be	F 0657		

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F 0657 SS=E	Continued from page 75 on EBP's. Observations of Resident 79's room on January 27, 2025, at 10:29 a.m. revealed that there was signage on the resident's door indicating that the resident was on EBP's. As of January 30, 2025, there was no documented evidence that the resident's care plan was revised/updated to include the EBP. Interview with Licensed Practical Nurse/Infection Control Preventionist on January 29, 2025, at 1:27 p.m. confirmed that there was no documented evidence to indicate that Resident 79's care plan was revised/updated to include the EBP's. A significant change MDS assessment for Resident 106, dated November 13, 2024, indicated that the resident was cognitively impaired, required assistance from staff with daily care needs, and had diagnosis that included Alzheimer's disease. Physician's orders for Resident 106, dated November 11, 2024, included an order for the resident to be admitted to hospice services with a	F 0657		

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F 0657 SS=E	Continued from page 76 diagnosis of Alzheimer's disease; however, Resident 106's care plan, dated November 6, 2024, indicated that the resident required comfort care. There was no documented evidence that Resident 106's care plan was updated to reflect that the resident was receiving hospice services. Interview with the Director of Nursing on January 30, 2025, at 8:43 a.m. confirmed that Resident 106's care plan was not updated when she started receiving hospice services. A quarterly MDS assessment for Resident 130, dated November 18, 2024, indicated that the resident was cognitively impaired, required assistance from staff with daily care needs, and had diagnoses that included respiratory failure. Physician's orders for Resident 130, dated May 11, 2024, included an order for the resident to receive 20 mg of Furosemide (diuretic) one time a day. An order to discontinue the Furosemide 20 mg was	F 0657		

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F 0657 SS=E	Continued from page 77 obtained on November 21, 2024; however, Resident 130's care plan, dated January 14, 2025, included the use of a diuretic. There was no documented evidence that Resident 130's care plan was updated to reflect the discontinuation of the diuretic. Interview with the Director of Nursing on January 28, 2025, at 1:35 p.m. confirmed that Resident 130's care plan was not updated after the discontinuation of the diuretic, and it should have been. 28 Pa. Code 211.12(d)(5) Nursing Services.	F 0657		
F 0658 SS=D		F 0658		

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(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 0658 SS=D	Continued from page 78 483.21(b)(3)(i) Services Provided Meet Professional Standards §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by:	F 0658	Preparation and submission of this Plan of Correction (POC) is required by state and federal law. This This Plan of Correction (POC) does not constitute an admission for purposes of general liability, professional malpractice or any other court proceeding Resident #2 careplan changes were completed and are accurate. Resident #25 careplan changes were completed and are accurate. Resident #41 careplan changes were completed and are accurate. Resident #64 careplan changes were completed and are accurate. Resident #79 careplan changes were completed and are accurate. Resident #106 careplan changes were completed and are accurate. Resident #130 careplan changes were completed and are accurate.	Completion Date: **03/17/2025** Status: **APPROVED** Date: **02/21/2025**

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F 0658 SS=D	Continued from page 79	F 0658	To identify other residents with the potential to be affected, the Director of Nursing/designee will review care plans to ensure any changes to code status, Enhanced Barrier Precautions, antibiotics, out of bed orders, hospice care and residents on diuretic medication within the last two weeks were reviewed/revised correctly on the care plan. To prevent a future occurrence, the Director of Nursing/designee provided education to the interdisciplinary team on the comprehensive care planning policy. To monitor and maintain ongoing compliance, the Director of Nursing/designee will complete an audit weekly x4 then monthly x2 to ensure any changes to orders are reflected on the care plan. Results of audits will be forwarded to facility's Quality Assurance and Process Improvement committee for review upon completion for review	

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F 0658 SS=D	Continued from page 80	F 0658	and recommendations. is required by state and federal law. This POC does not constitute an admission for purposes of general liability, professional malpractice or any other court proceeding Resident #69 handwritten order for wound care was to cleanse the wound; order entered into the computer that was followed was to cleanse the wound. Clarification for the order was obtained at the time of the survey to "cleanse the wound". To identify other residents with the potential to be affected, the Director of Nursing/designee will review wound consult notes and handwritten orders for the last 2 weeks to ensure they match and get any clarification if needed. To prevent a future occurrence, the Director of Nursing/designee provided education to the licensed staff on ensuring progress notes from the wound Certified Registered Nurse Practioner (CRNP), match the	

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F 0658 SS=D	Continued from page 81	F 0658	handwritten order and get clarification if needed. Education was also provided to the wound CRNP to ensure that his orders in his notes match his handwritten orders. To monitor and maintain ongoing compliance, the Director of Nursing/designee will complete an audit weekly x4 then monthly x2 on wound care orders and wound care progress notes to ensure accuracy and consistency. Results of audits will be forwarded to facility's Quality Assurance and Process Improvement committee for review upon completion for review and recommendations	

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F 0658 SS=D	Continued from page 82 Based on review of Pennsylvania's Nursing Practice Act and clinical records, as well as staff interviews, it was determined that the facility failed to clarify an order for treatment for one of 66 residents reviewed (Resident 69). Findings include: The Pennsylvania Code, Title 49, Professional and Vocational Standards, State Board of Nursing, 21.11 (a)(1)(2)(4) indicated that the registered nurse was to collect complete and ongoing data to determine nursing care needs, analyze the health status of individuals and compare the data with the norm when determining nursing care needs, and carry out nursing care actions that promote, maintain and restore the well-being of individuals. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs), dated November 2, 2024, indicated that Resident 69 was alert and oriented, required	F 0658		

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F 0658 SS=D	Continued from page 83 assistance from staff with care, and had a non-healing surgical wound. A wound consult report for Resident 69, dated December 24, 2024, recommended that the resident's wound was to be cleansed with VASHE (a wound cleanser intended for cleansing, irrigating, moistening, debridement and removal of foreign material), medi-honey applied to alginate that was cut to fit the wound and covered with a foam dressing. However, the resident's Treatment Administration Record (TAR), dated December 2024, revealed that the staff were not using VASHE wound cleanser and were not applying alginate to the wound. A wound consult report for Resident 69, dated December 31, 2024, and January 7, 2025, recommended that the resident's wound was to soak in VASHE for 15 minutes, then be cleansed with VASHE, and to apply medihoney with biofilm dressing. However, the resident's TAR, dated December 2024 and January 2025, indicated that	F 0658		

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F 0658 SS=D	Continued from page 84 staff were not soaking the resident's wound with VASHE and were not using VASHE cleanser. Interview with the Director of Nursing on January 29, 2025, at 3:00 p.m. revealed that the Wound Nurse Practitioner wrote orders that did not match the wound consultant's recommendations and nursing staff did not read the wound consultant's notes in order to compare his dictation with the orders. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing Services.	F 0658		
F 0661 SS=D		F 0661		

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F 0661 SS=D	Continued from page 85 483.21(c)(2)(i)-(iv) Discharge Summary §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services. This REQUIREMENT is not met as evidenced by:	F 0661	Preparation and submission of this Plan of Correctio (POC) is required by state and federal law. This POC does not constitute an admission for purposes of general liability, professional malpractice or any other court proceeding Facility is unable to create the discharge summary for Resident #149. To identify other residents with the potential to be affected, the Director of Nursing/designee will audit the last month of discharged residents to ensure the discharge summary was completed and make corrections if applicable/able. To prevent a future occurrence, the Director of Nursing/designee will educate nursing staff on how to properly complete a discharge summary. To monitor and maintain ongoing compliance, the Director of Nursing/designee will complete an	Completion Date: **03/17/2025** Status: **APPROVED** Date: **02/21/2025**

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F 0661 SS=D	Continued from page 86	F 0661	audit of discharged residents to ensure the discharge summary was completed weekly x4 and then monthly x2. Results of audits will be forwarded to facility's Quality Assurance and Process Improvement committee for review upon completion for review and recommendations.	

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F 0661 SS=D	Continued from page 87 Based on clinical record reviews and staff interviews, it was determined that the facility failed to ensure that discharge instructions that included post-discharge medications and a post-discharge plan of care was completed for one of three discharged residents reviewed (Resident 149). Findings include: A nursing note for Resident 149, dated October 31, 2024, at 7:31 p.m. revealed that the resident was picked up by a transport company to discharge to another facility. As of October 30, 2024, there was no documented evidence that Resident 149 was provided discharge instructions that included post-discharge medications or a post-discharge plan of care. Interview with the Assistant Nursing Home Administrator on January 30, 2025, at 3:25 p.m. confirmed that there was no documented evidence	F 0661		

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F 0661 SS=D	Continued from page 88 that Resident 149 was provided discharge instructions that included post-discharge medications or a post-discharge plan of care. 28 Pa. Code 211.5(d) Clinical Records. 28 Pa. Code 211.9(j.1)(4) Pharmacy Services.	F 0661		
F 0679 SS=E		F 0679		

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F 0679 SS=E	Continued from page 89 483.24(c)(1) Activities Meet Interest/Needs Each Resident §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by:	F 0679	Preparation and submission of this Plan Of Correction (POC) is required by state and federal law. This POC does not constitute an admission for purposes of general liability, professional malpractice or any other court proceeding Resident #9 activity preferences and care plan were updated. To identify other residents with the potential to be affected, the Life Enrichment Director/designee will complete 100% audit of all residents to identify those at risk and in need of a 1:1 visit. To prevent a future occurrence, Life Enrichment Director will create a separate calendar listing the residents who trigger for a 1:1 visit based on the observation completed. Life Enrichment Director/designee will educate Life Enrichment Staff on how this process designed will work moving forward within the department and facility.	Completion Date: **03/17/2025** Status: **APPROVED** Date: **02/21/2025**

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F 0679 SS=E	Continued from page 90	F 0679	To monitor and maintain ongoing compliance, Life Enrichment Director/designee will monitor the monthly activity logs for residents with Care plans for 1 to 1 visit weekly x4 and then monthly x2. Results of audits will be forwarded to facility's Quality Assurance and Process Improvement committee for review upon completion for review and recommendations.	

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F 0679 SS=E	Continued from page 91 Based on a review of facility policies and clinical records, as well as resident family and staff interviews, it was determined that the facility failed to provide adequate, ongoing activities designed to meet the needs of residents for one of 66 residents reviewed (Resident 9). Findings include: The facility's life enrichment programming policy, dated December 30, 2024, indicated that an ongoing resident-centered life enrichment program, based on comprehensive assessments and care plans, will be provided. The program will be designed to meet the interests (including hobbies and cultural preferences) and the abilities of each resident including their physical, mental, emotional, social, spiritual, psychological, and leisure needs. Programs will be scheduled and offered seven days a week, including evening and weekend programs. Adaptations will be made as necessary to enhance the resident's enjoyment of, or participation in,	F 0679		

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F 0679 SS=E	Continued from page 92 programming. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 9, dated November 4, 2024, revealed that the resident was understood, could understand others, and had a diagnosis which included hemiplegia (paralysis to one side of the body) and dysphagia (swallowing difficulties) following a cerebral vascular accident (CVA - commonly known as a stroke). A care plan for the resident, dated February 20, 2024, revealed that the resident may be at risk for reduced activity involvement related to his diagnosis, and that the resident needs one-to-one bedside/in-room visits and activities if he is unable to attend out-of-room events. Review of Resident 9's activity documentation, dated November and December 2024 and January 2025, revealed that there was no documented evidence that the resident was involved in or refused involvement in an activity or one-to-one during the	F 0679		

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F 0679 SS=E	Continued from page 93 week of November 10 through 16, 2024; during the week of November 17 through 23, 2024; during the week of November 24 through 30, 2024; during the week of December 1 through 7, 2024; during the week of January 5 through 11, 2025; during the week of January 12 through 18, 2025; and during the week of January 19 through 25, 2025. Interview with Resident 9's spouse/POA on January 27, 2025, at 10:10 a.m. revealed that Resident 9 does not like to get out of bed and that the facility does not provide the resident with any in-room activities. She indicated that all he has to do is watch TV. Interview with the Activities Director on January 30, 2025, at 2:45 p.m. revealed that they will assess residents' activities preferences at least quarterly. If there is a noted change that is brought to her attention, she will also assess the resident. She indicated that Resident 9 was scheduled to have one-to-one bedside/in-room visits and activities weekly and confirmed that there was no	F 0679		

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F 0679 SS=E	Continued from page 94 documented evidence that the resident received one-to-one bedside/in-room visits and activities weekly on the above weeks. 28 Pa. Code 211.12(d)(3)(5) Nursing Services.	F 0679		
F 0684 SS=D		F 0684		

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F 0684 SS=D	Continued from page 95 483.25 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	Preparation and submission of this Plan Of Correction (POC) is required by state and federal law. This POC does not constitute an admission for purposes of general liability, professional malpractice or any other court proceeding Resident #44 and Resident #79 did not suffer any adverse reactions. Resident #44 medication order is accurate. Resident #79 does not have any procedures scheduled at this time that require a medication to be on hold. To identify other residents with the potential to be affected, the Director of Nursing/designee will audit residents who were to have procedures completed in the last two weeks to ensure medications that were to be held were and any medications that were put on hold had dates extended if needed.	Completion Date: **03/17/2025** Status: **APPROVED** Date: **02/21/2025**

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	395828	A. BLDG: __00_____ B. WING: _____	01/30/2025

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F 0684 SS=D	Continued from page 96	F 0684	To prevent a future occurrence, the Director of Nursing/designee will educate licensed nursing staff on how to properly place medications on hold and follow consult recommendations to place medications on hold. To monitor and maintain ongoing compliance, an audit of scheduled procedures and order holds will be completed weekly x4 and then monthly x2. Results of audits will be forwarded to facility's Quality Assurance and Process Improvement committee for review upon completion for review and recommendations.	

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F 0684 SS=D	Continued from page 97 Based on review of clinical records and personnel files, as well as staff interviews, it was determined that the facility failed to ensure that physician's orders were followed for one of 66 residents reviewed (Resident 44), and failed to follow recommendations from a interventional radiology consultation for one of 66 residents reviewed (Resident 79). Findings include: A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 44, dated November 20, 2024, indicated that the resident was cognitively impaired, received pain medication routinely, and received an opioid. Physician's orders, dated November 25, 2024, included an order for the resident to receive 12 micrograms per hour (mcg/hr) of fentanyl (a narcotic pain patch) patch to be applied every 72 hours for pain. A physician's order, dated December 19, 2024, included an order	F 0684		

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F 0684 SS=D	Continued from page 98 to hold the fentanyl patch until December 20, 2024. A controlled drug accountability record (tracks each dose of a controlled medication) for Resident 44's 12 mcg/hr fentanyl patches revealed that one patch was signed out on the controlled drug log as being applied on December 20, 2024, at 8:00 a.m. and the next patch was applied on December 22, 2024, at 8:00 a.m. (48 hours). Interview with the Director of Nursing on January 29, 2025, at 1:16 p.m. confirmed that staff applied the resident's fentanyl patch in 48 hours, instead of the ordered 72 hours. The date the fentanyl patch should have been applied after December 20, 2024, was on December 23, 2024. Physician's orders for Resident 79, dated November 15, 2024, included an order for the resident to receive one 75 milligram (mg) tablet of clopidogrel (Plavix - an antiplatelet drug to prevent blood clots) once a day.	F 0684		

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F 0684 SS=D	Continued from page 99 An Interventional Radiology (a medical specialty that uses minimally invasive procedures to diagnose and treat patients) Consult for Resident 79, dated December 30, 2024, revealed that the resident was scheduled for a procedure on January 16, 2025, at 9:00 a.m. for a suprapubic catheter (a thin, flexible tube that is inserted through the abdominal wall into the bladder to drain urine) exchange. The resident was to stop the Plavix five days before the procedure on January 16, 2025. Review of Resident 79's MAR's, dated January 2025, revealed that the resident was administered the 75 mg tablet of clopidogrel (Plavix) on January 11 through 16, 2025. Interview with the Director of Nursing on January 30, 2025, at 11:10 a.m. confirmed that the clopidogrel (Plavix) was not stopped five days before the procedure on January 16, 2025. 28 Pa. Code 211.12(d)(1)(5) Nursing Services.	F 0684		

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F 0684 SS=D	Continued from page 100	F 0684		
F 0689 SS=D		F 0689		

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F 0689 SS=D	Continued from page 101 483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by:	F 0689	Preparation and submission of this Plan of Correction (POC) is required by state and federal law. This POC does not constitute an admission for purposes of general liability, professional malpractice or any other court proceeding Resident #64 and Resident #120 did not have any adverse reactions from being transported without leg rests. Resident #64 and Resident #120 will have, moving forward, leg rests on when being transported by staff. There were no other identified issues at the time of the survey. To prevent a future occurrence, the Director of Nursing/designee provided education to staff on the seating and positioning policy. The education included using wheelchair legs for transporting. To monitor and maintain ongoing compliance, the Director of Nursing/designee will complete an	Completion Date: **03/17/2025** Status: **APPROVED** Date: **02/21/2025**

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F 0689 SS=D	Continued from page 102	F 0689	audit weekly x4 then monthly x2 to ensure staff transporting residents are utilizing leg rests. Results of audits will be forwarded to facility's Quality Assurance and Process Improvement committee for review upon completion for review and recommendations.	

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F 0689 SS=D	Continued from page 103 Based on clinical record reviews, observations, and staff interviews, it was determined that the facility failed to ensure that each resident received assistance devices to prevent accidents for two of 66 residents reviewed (Residents 64, 120). Findings include: A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 64, dated November 6, 2024, revealed that the resident was cognitively impaired, required assistance from staff for personal care needs, and had diagnoses that included dementia. Physician's orders for Resident 64, dated January 20, 2025, included an order for the resident to be out of bed to an evolution chair in the upright position with bilateral standard leg rests for transport and outside only.	F 0689		

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F 0689 SS=D	Continued from page 104 Review of the care plan for Resident 64, dated July 11, 2023, revealed that the resident was at risk for falls and that bilateral leg rests were to be used for transport only and outside. Observations of Resident 64 on January 27, 2025, at 10:35 a.m. revealed that the resident was transported in her chair by Nurse Aide 8 from her bedroom to the small activity room on the fourth floor with no footrests on her chair. An interview with Nurse Aide 8 at the time of the observation revealed that she did not apply leg rests to Resident 64's chair prior to transporting the resident and she should have. A quarterly MDS assessment for Resident 120, dated November 13, 2024, revealed that the resident was cognitively impaired, required assistance from staff for personal care needs, and had diagnoses that included dementia. Physician's orders for Resident 120, dated October 11, 2024, included for the resident to be out of bed	F 0689		

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F 0689 SS=D	Continued from page 105 in a scoot chair with standard leg rests for transport and outside. Review of the care plan for Resident 120, dated September 23, 2023, revealed that the resident was at risk for falls and that standard leg rests were to be used for transport and outside. Observations of Resident 120 on January 27, 2025, at 10:05 a.m. revealed that the resident was transported on her chair from the activity room at the end of the hall to the area in front of the nurses' station by Licensed Practical Nurse 9 with no leg rests on her chair. An interview with Licensed Practical Nurse 9 at the time of the observation revealed that she transported the resident because she was being disruptive to other residents and that she did not apply leg rests prior to transporting her. An interview with the Director of Nursing on January 28, 2025, at 1:37 p.m. confirmed that footrests should have been used as ordered when transporting Residents 64 and 120.	F 0689		

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F 0689 SS=D	Continued from page 106 28 Pa. Code 211.10(c)(d) Resident Care Policies. 28 Pa. Code 211.12(d)(5) Nursing Services.	F 0689		
F 0711 SS=D		F 0711		

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F 0711 SS=D	Continued from page 107 483.30(b)(1)-(3) Physician Visits - Review Care/Notes/Order §483.30(b) Physician Visits The physician must- §483.30(b)(1) Review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section; §483.30(b)(2) Write, sign, and date progress notes at each visit; and §483.30(b)(3) Sign and date all orders with the exception of influenza and pneumococcal vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications. This REQUIREMENT is not met as evidenced by:	F 0711	Preparation and submission of this Plan Of Correction (POC) is required by state and federal law. This POC does not constitute an admission for purposes of general liability, professional malpractice or any other court proceeding The facility is not able to obtain previous physician note for Resident #84. At the time of the survey, the facility obtained the note for Resident #84 from the Certified Registered Nurse Practitioner. At the time of the survey, the facility obtained the note for Resident #79 from the physician. To identify other residents with the potential to be affected, the Director of Nursing/designee will audit a 2 week look back of physician and certified Registered Nurse Practitioner visits to ensure notes are present.	Completion Date: **03/17/2025** Status: **APPROVED** Date: **02/20/2025**

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F 0711 SS=D	Continued from page 108	F 0711	To prevent a future occurrence, the Director of Nursing/designee provided education to the physician and Certified Registered Nurse Practitioner on writing a note for each resident that they visit. To monitor and maintain ongoing compliance, the Director of Nursing/designee will complete an audit weekly x4 then monthly x2 to verify a note is present for each resident that they visit. Results of audits will be forwarded to facility's Quality Assurance and Process Improvement committee for review upon completion for review and recommendations.	

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F 0711 SS=D	Continued from page 109 Based on clinical record reviews and staff interviews, it was determined that the facility failed to ensure that the physician and the Certified Registered Nurse Practitioner (CRNP - a registered nurse with advanced training) wrote, signed, and dated progress notes with each visit for two of 66 residents reviewed (Residents 79, 84). Findings include: A nursing note for Resident 79, dated December 31, 2024, revealed that the resident was seen at the bedside by the physician. New verbal orders were received. As of January 30, 2025, there was no documented evidence in Resident 79's clinical record that the physician completed a progress note for his visit on December 31, 2024. Interview with the Director of Nursing on January 30, 2025, 11:10 a.m. confirmed that there was no documented evidence in Resident 79's clinical record that the physician completed a progress note	F 0711		

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F 0711 SS=D	Continued from page 110 for his visit on December 31, 2024, until today when he faxed the progress note to the facility. A nursing note for Resident 84, dated November 2, 2024, revealed that the resident was a new admit to the facility from the hospital. As of January 29, 2025, there was no documented evidence in Resident 84's clinical record that the physician completed a progress note for his initial admission visit for the resident's admission to the facility. Interview with the Director of Nursing on January 29, 2024, at 8:29 a.m. confirmed that there was no documented evidence in Resident 84's clinical record that the physician completed a progress note for his initial admission visit for the resident's admission to the facility. She indicated that she spoke with the physician, and he recalls seeing the resident, but she is unable to locate a progress note for the resident. Hospital discharge instructions for Resident 84,	F 0711		

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F 0711 SS=D	Continued from page 111 dated January 18, 2025, revealed that the resident was to have the sutures removed from her left eyebrow on January 23, 2025. As of January 28, 2025, there was no documented evidence in Resident 84's clinical record that the CRNP completed a progress note regarding the removal of the resident's sutures to her left eyebrow. Interview with Licensed Practical Nurse/Infection Control Preventionist on January 28, 2025, at 12:29 p.m. confirmed that there was no documented evidence in Resident 84's clinical record that the CRNP completed a progress note regarding the removal of the resident's sutures to her left eyebrow. She indicated that she spoke with the CRNP, and she advised her that she was only able to remove a few of the sutures at that time and that she was behind putting her progress notes in the residents' clinical records. 28 Pa. Code 211.5(f) Clinical Records.	F 0711		

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F 0755 SS=E		F 0755		

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(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 0755 SS=E	Continued from page 113 483.45(a)(b)(1)-(3) Pharmacy Srvcs/Procedures/Pharmacist/Records §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.	F 0755	Preparation and submission of this Plan Of Correction (POC) is required by state and federal law. This POC does not constitute an admission for purposes of general liability, professional malpractice or any other court proceeding The facility could not go back and fix Resident #44 destruction log. The facility could not go back and fix the accountability log for Resident #149 narcotic at time of discharge. To identify other residents with the potential to be affected, the Director of Nursing/designee will audit Fentanyl destruction logs for the last 30 days to ensure two signatures are present and review residents discharged over the last 2 weeks to ensure accountability of narcotics if resident was to be discharged with them. To prevent a future occurrence, the Director of Nursing/designee will educate licensed nursing staff on the	Completion Date: **03/17/2025** Status: **APPROVED** Date: **02/20/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395828	A. BLDG: __00_____ B. WING: _____	01/30/2025

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F 0755 SS=E	Continued from page 114 This REQUIREMENT is not met as evidenced by:	F 0755	proper destruction of medications and medication disposition of discharged residents. To monitor and maintain ongoing compliance, the Director of Nursing/designee will audit Fentanyl destruction logs and accountability of narcotics on discharge weekly x4 and then monthly x2 to ensure two signatures are present and residents are discharged with narcotics if ordered by Medical Director (MD). Results of audits will be forwarded to facility's Quality Assurance and Process Improvement committee for review upon completion for review and recommendations.	

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 0755 SS=E	Continued from page 115 Based on review of facility policies and clinical records, as well as staff interviews, it was determined that the facility failed to maintain accountability for controlled medications (drugs with the potential to be abused) for two of 66 residents reviewed (Residents 44, 149). Findings include: The facility's policy/procedure regarding fentanyl patch destruction, dated December 30, 2024, indicated that licensed nurses would remove fentanyl patches, when appropriate, using gloved hands and fold the patch in half so that the adhesive side adhered to itself. With a witness, the patch would be disposed of in the sharps container (a puncture-resistant container used to safely dispose of sharp objects like needles and syringes). Two licensed nurses were to witness and document the disposal of all fentanyl patches. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and	F 0755		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0755 SS=E	Continued from page 116 care needs) for Resident 44, dated November 20, 2024, indicated that the resident was cognitively impaired, received pain medication routinely, and received an opioid. Physician's orders, dated November 25, 2024, included an order for the resident to receive 12 micrograms per hour (mcg/hr) of fentanyl (a narcotic pain patch) patch to be applied every 72 hours for pain. A controlled drug accountability record (tracks each dose of a controlled medication) for Resident 44's 12 mcg/hr fentanyl patches revealed that one patch was signed out on the controlled drug log on December 31, 2024, at 8:00 a.m.; January 3, 2025, at 8:00 a.m.; January 6, 2025, at 8:00 a.m.; January 9, 2025, at 8:00 a.m.; January 12, 2025, at 8:00 a.m.; and January 27, 2025, at 8:00 a.m. However, there was no documented evidence that two staff members signed that the old patch was destroyed after removal. Interview with the Director of Nursing on January 29, 2025, at 1:16 p.m. revealed that two nurses	F 0755		

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 0755 SS=E	Continued from page 117 were to sign when a fentanyl patch was removed and destroyed, and confirmed that there was no documented evidence that two nurses destroyed Resident 44's old fentanyl patch on the dates above. A discharge Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 149, dated October 31, 2024, revealed that the resident was discharged to a nursing facility on October 31, 2024, with a return not anticipated. Current physician's orders for Resident 149 included an order for the resident to receive one milligram (mg) of Ativan (a controlled drug used to treat anxiety) every six hours. A nursing note for Resident 149, dated October 31, 2024, at 1:47 p.m. revealed that the family was updated on new orders for Ativan prior to departure and for discharge. A nursing note, dated October 31, 2024, at 7:31 p.m., revealed that Resident 149 was picked up by a transport company for her discharge to a nursing facility in another state. There was no documented evidence that the disposition of	F 0755		

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 0755 SS=E	Continued from page 118 Ativan was completed for Resident 149 on discharge. Interview with the Assistant Nursing Home Administrator on January 20, 2025, confirmed that there was no documented evidence of the medication disposition of Resident 149's Ativan upon discharge. 28 Pa. Code 211.9(a)(j.1)(4) Pharmacy Services. 28 Pa. Code 211.12(d)(1)(5) Nursing Services.	F 0755		
F 0761 SS=D		F 0761		

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F 0761 SS=D	Continued from page 119 483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by:	F 0761	Preparation and submission of this Plan Of Correction (POC) is required by state and federal law. This POC does not constitute an admission for purposes of general liability, professional malpractice or any other court proceeding Resident #32, Resident #135, Resident #48 and Resident #95 undated medications were discarded at the time of the survey. To identify other residents with the potential to be affected, the Director of Nursing/designee will audit med carts to ensure that resident inhalers are dated properly. To prevent a future occurrence, the Director of Nursing/designee provided education to licensed nursing staff on the storage and expiration dating of medications and biologicals policy. To monitor and maintain ongoing compliance, the Director of Nursing/designee will complete an	Completion Date: **03/17/2025** Status: **APPROVED** Date: **02/20/2025**

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F 0761 SS=D	Continued from page 120	F 0761	audit weekly x4 then monthly x2 to ensure that multi-dose vials are being dated properly. Results of audits will be forwarded to facility's Quality Assurance and Process Improvement committee for review upon completion for review and recommendations.	

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F 0761 SS=D	Continued from page 121 Based on a review of facility policies, manufacturer's instructions, and clinical records, as well as observations and staff interviews, it was determined that the facility failed to label multi-dose containers of medications with the date they were opened in one of four medication carts observed (First-Floor Southeast medication cart). Findings include: The facility's policy regarding storage and expiration dating of medications, dated December 30, 2024, revealed that once any medication or biological package is opened, the facility should follow manufacture/supplier guidelines with respect expiration dates for opened medications. Facility staff should record the date opened on the primary medication container when the medication has a shortened expiration date once opened. Manufacturer's directions on the container for use of fluticasone propion-salmeterol (used to control and	F 0761		

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F 0761 SS=D	Continued from page 122 prevent symptoms (wheezing and shortness of breath) caused by asthma or ongoing lung disease) inhaler revealed that the inhaler was to be discarded one month after being removed from the foil pouch. Physician's orders for Resident 32, dated January 12, 2025, included an order for the resident to receive one 250-50 microgram (mcg) puff from the fluticasone propion-salmeterol inhaler twice a day. Physician's orders for Resident 135, dated December 31, 2024, included an order for the resident to receive one 500-50 mcg puff from the fluticasone propion-salmeterol inhaler twice a day. Manufacturer's directions on the container for use of umeclidinium-vilanterol (used to treat chronic obstructive pulmonary disease (COPD), a condition that causes inflammation and narrowing of the airways) inhaler revealed that the inhaler was to be discarded six weeks after being removed from the foil pouch.	F 0761		

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F 0761 SS=D	Continued from page 123 Physician's orders for Resident 48, dated December 31, 2024, included an order for the resident to receive one 62.5-25 mcg puff from the umeclidinium-vilanterol inhaler once a day. Manufacturer's directions on the container for use of fluticasone-umeclidinium-vilanterol (a combination medication used to treat COPD and asthma) inhaler revealed that the inhaler was to be discarded six weeks after being removed from the foil pouch. Physician's orders for Resident 95, dated June 26, 2024, included an order for the resident to receive one 200-62.5-25 mcg puff from the fluticasone-umeclidinium-vilanterol inhaler once a day. Observations of the First-Floor Southeast medication cart on January 29, 2025, at 1:35 p.m. revealed that the 250-50 mcg fluticasone propion-salmeterol inhaler for Resident 32, the 62.5-25 mcg umeclidinium-vilanterol inhaler for Resident 48, the 200-62.5-25 mcg	F 0761		

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F 0761 SS=D	Continued from page 124 fluticasone-umeclidinium-vilanterol inhaler for Resident 95, and the 500-50 mcg puff from the fluticasone propion-salmeterol inhaler for Resident 135 were opened and not dated with the dates that they were opened. Interview with Licensed Practical Nurse 10 at the time of observation confirmed that the inhalers for Residents 32, 48, 95, and 135's were opened and not dated with the date they were opened, and they should have been dated. 28 Pa. Code 211.9(h) Pharmacy Services. 28 Pa. Code 211.12(d)(1) Nursing Services.	F 0761		
F 0770 SS=D		F 0770		

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F 0770 SS=D	Continued from page 125 483.50(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	Preparation and submission of this Plan of Correction (POC) is required by state and federal law. This POC does not constitute an admission for purposes of general liability, professional malpractice or any other court proceeding Resident #58 did not have any adverse reactions. Resident #120 did not have any adverse reactions. To identify other residents with the potential to be affected, the Director of Nursing/designee will audit residents from the last 2 weeks who had an order for a Urine Analysis (UA) to ensure it was obtained timely. To prevent a future occurrence, the Director of Nursing/designee will educate licensed nursing staff on how to properly place an order for a UA and ensure it is picked up from the lab timely. Lab now has a routine schedule of being at the facility on	Completion Date: **03/17/2025** Status: **APPROVED** Date: **02/21/2025**

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F 0770 SS=D	Continued from page 126	F 0770	Monday, Wednesday, Thursday and Friday and if it is a STAT then we call them. To monitor and maintain ongoing compliance, the Director of nursing/designee with review orders placed for a UA daily in clinical morning meeting weekly x4 and then monthly x2 to ensure urines are obtained and collected timely. Results of audits will be forwarded to facility's Quality Assurance and Process Improvement committee for review upon completion for review and recommendations.	

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F 0770 SS=D	Continued from page 127 Based on clinical record review and staff interview, it was determined the facility failed to ensure timely completion of prescribed laboratory services for two of 66 residents reviewed (Residents 58, 120). Findings include: A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 58, dated October 25, 2024, revealed that the resident was understood and could understand others, required assistance from staff for daily care needs, and had a diagnosis of dementia. Physician's orders for Resident 58, dated October 8, 2024, included an order for staff to obtain a urinalysis (lab test that can detect a urinary tract infection) and culture and sensitivity (identifies the specific microorganism causing an infection). May straight catherize (use a small, flexible tube to drain urine from the bladder) the resident to obtain. Once	F 0770		

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F 0770 SS=D	Continued from page 128 obtained, place specimen in laboratory refrigerator and call the lab for pick up. A nurse's note for Resident 58, dated October 8, 2024, at 2:05 p.m., revealed that a urine for a urinalysis was obtained via straight cath. The lab did not pick up the specimen. Physician's orders for Resident 58, dated October 10, 2024, included an order for staff to obtain a urinalysis and culture and sensitivity. May straight cath the resident to obtain. Once obtained, place specimen in laboratory refrigerator and call the lab for pick up. A nurse's note for Resident 58, dated October 10, 2024, at 2:56 p.m., revealed that a urine for a urinalysis was obtained via straight cath, and that the lab was called and made aware of specimen. A nurse's note for Resident 58, dated October 11, 2024, at 3:57 p.m., revealed that the preliminary results of the urinalysis were reviewed by the	F 0770		

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F 0770 SS=D	Continued from page 129 Certified Registered Nurse Practitioner (registered nurse with additional education and training that allows them to work under a wider scope of practice) and new orders were received for Keflex (an antibiotic) twice a day for five days. A quarterly MDS assessment for Resident 120, dated November 13, 2024, revealed that the resident was cognitively impaired, required assistance from staff for personal care needs, and had diagnoses that included dementia. A nurse's note for Resident 120, dated January 22, 2025, at 4:10 p.m. revealed that orders were received to obtain a urinalysis related recent falls and agitation. A nurse's note, dated January 23, 2025, at 4:05 p.m. revealed that a urinalysis sample was obtained that morning and the lab was notified to pick it up. A nurse's note for Resident 120, dated January 24, 2025, at 12:18 p.m. revealed that the resident's urine sample was found in the refrigerator and was	F 0770		

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F 0770 SS=D	Continued from page 130 not picked up by the lab. The Certified Registered Nurse Practitioner ordered to prophylactically treat the resident for a urinary tract infection. Review of urinalysis results for Resident 120, dated January 25, 2025, indicated that the resident did not have a urinary infection. Interview with the Director of Nursing on January 30, 2025, at 8:43 a.m. revealed that Resident 58 was straight catherized twice for a urinalysis two days apart because the lab never picked up the urine that was obtained on October 8, 2024. The Director of Nursing further revealed that the hospital lab is responsible for picking up lab specimens and that staff were unaware when labs were not picked up timely. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing Services.	F 0770		
F 0773 SS=D		F 0773		

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F 0773 SS=D	Continued from page 131 483.50(a)(2)(i)(ii) Lab Srvcs Physician Order/Notify of Results §483.50(a)(2) The facility must- (i) Provide or obtain laboratory services only when ordered by a physician; physician assistant; nurse practitioner or clinical nurse specialist in accordance with State law, including scope of practice laws. (ii) Promptly notify the ordering physician, physician assistant, nurse practitioner, or clinical nurse specialist of laboratory results that fall outside of clinical reference ranges in accordance with facility policies and procedures for notification of a practitioner or per the ordering physician's orders. This REQUIREMENT is not met as evidenced by:	F 0773	Preparation and submission of this Plan of Correction (POC) is required by state and federal law. This POC does not constitute an admission for purposes of general liability, professional malpractice or any other court proceeding Resident #84 did not suffer any adverse effects from the urine being obtained via straight cath. Resident #18 did not suffer any adverse effects from the lab not being obtained and had a Thyroid stimulating hormone (TSH) drawn on 1/3/25 which was within normal limits. To identify other residents with the potential to be affected, the Director of Nursing/designee will review labs for the prior 2 weeks to ensure labs were obtained as ordered and review any that were not with the medical director to see if they need reordered. To prevent a future occurrence, the	Completion Date: **03/17/2025** Status: **APPROVED** Date: **02/20/2025**

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F 0773 SS=D	Continued from page 132	F 0773	Director of Nursing/designee will educate licensed nursing staff on how to properly place laboratory orders and verify labs were obtained. Education will include obtaining doctors orders for invasive procedures. To monitor and maintain ongoing compliance, laboratory orders will be reviewed weekly x4 and then monthly x2 to ensure labs are obtained when ordered. the check to ensure labs are obtained as ordered is that they are triggered to the Medication Administration Record (MAR) for sign off Results of audits will be forwarded to facility's Quality Assurance and Process Improvement committee for review upon completion for review and recommendations.	

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F 0773 SS=D	Continued from page 133 Based on clinical record reviews and staff interviews, it was determined that the facility failed to obtain laboratory studies as ordered by the physician for one of 66 residents reviewed (Resident 18) and failed to obtain a physician's order for an invasive procedure to collect a specimen for a laboratory test for one of 66 residents reviewed (Resident 84). Findings include: A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 18, dated December 16, 2024, revealed that the resident was cognitively intact and had diagnoses that included hypothyroidism (a condition in which the thyroid gland does not produce enough thyroid hormone). Physician's orders for Resident 44, dated June 2, 2024, included an order for staff to obtain a TSH (Thyroid Stimulating Hormone - test used to identify	F 0773		

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F 0773 SS=D	Continued from page 134 the amount of hormones secreted by the thyroid) on the first Monday of March, June, September, and December. There was no documented evidence that staff obtained Resident 18's TSH for September and December 2024. Interview with Director of Nursing on January 29, 2025, at 4:36 p.m. confirmed that there was no evidence that Resident 18's TSH was obtained for September and December 2024. A quarterly MDS assessment for Resident 84, dated December 17, 2024, revealed that the resident was understood, could understand others, and had diagnoses that included End-Stage Renal Disease (ESRD - a severe and permanent condition where the kidneys have lost most of their function and can no longer adequately filter waste products and excess fluid from the blood) with dependence on hemodialysis (mechanical cleansing of the blood	F 0773		

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F 0773 SS=D	Continued from page 135 for a person whose kidneys are not functioning normally). Physician's orders for Resident 84, dated January 16, 2025, included an order for staff to obtain a urine specimen and call the hospital's laboratory when obtained. A progress note for Resident 84, dated January 16, 2025, revealed that the writer attempted to straight cath (the insertion of a plastic tube into the bladder) the resident at this time to obtain a urinalysis and culture and sensitivity (UA C&S - urine tests to check for the presence of bacteria and determine which antibiotics the bacteria is sensitive to). There was no documented evidence that staff obtained a physician's order to obtain Resident 84's urine specimen via catheterization. Interview with the Licensed Practical Nurse/Infection Control Preventionist on January 28, 2025, at 12:29 p.m. confirmed that there was	F 0773		

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F 0773 SS=D	Continued from page 136 no evidence that a physician's order was obtained for Resident 84 to be catheterized to obtain the urine specimen on January 16, 2025. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing Services.	F 0773		
F 0867 SS=E		F 0867		

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F 0867 SS=E	Continued from page 137 483.75(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	Preparation and submission of this Plan Of Correction (POC) is required by state and federal law. This POC does not constitute an admission for purposes of general liability, professional malpractice or any other court proceeding The facility is unable to fix the Quality Assurance audits at the time of the survey. There were no other issues identified at the time of the survey. To prevent a future occurrence, the Nursing Home Administrator will educate department heads on the Quality Assurance and Process Improvement Policy. To monitor and maintain ongoing compliance, the Nursing Home Administrator/designee will complete an audit weekly x4 then monthly x2 to ensure that audits are being completed, reviewed and have process improvement plans put into place if necessary.	Completion Date: **03/17/2025** Status: **APPROVED** Date: **02/20/2025**

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F 0867 SS=E	Continued from page 138 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	Results of audits will be forwarded to facility's Quality Assurance and Process Improvement committee for review upon completion for review and recommendations.	

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F 0867 SS=E	Continued from page 139 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=E	Continued from page 140 (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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F 0867 SS=E	Continued from page 141 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 maintain compliance with nursing home regulations 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 State Survey and Certification (Department of Health) surveys ending February 14, 2024; June 4, 2024; June 20, 2024; and August 1, 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 30, 2025, identified repeated deficiencies related to a failure to prevent resident abuse/neglect; timely completion of comprehensive	F 0867		

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F 0867 SS=E	Continued from page 142 assessments; accuracy of Minimum Data Set (MDS) assessments (mandated assessment of a resident's abilities and care needs); development of comprehensive care plans; failure to provide professional nursing services; failure to provide safety/prevent accidents; failure to ensure the physician and the certified registered nurse practitioner wrote, signed, and dated progress notes with each visit; preventing issues with the accountability of controlled medications (drugs with the potential to be abused); properly store and label medications; and to ensure proper infection control practices were followed. The facility's plan of correction for a deficiency regarding compliance with preventing resident abuse/neglect, cited during the survey ending June 4, 2024, revealed that the facility would complete audits and report the results of the audits to the QAPI committee for review. The results of the current survey, cited under F600, revealed that the facility's QAPI committee was ineffective in maintaining compliance with preventing resident	F 0867		

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F 0867 SS=E	Continued from page 143 abuse/neglect. The facility's plan of correction for a deficiency regarding timely completion of comprehensive assessments, cited during the survey ending February 14, 2024, revealed that the facility would complete audits and report the results of the audits to the QAPI committee for review. The results of the current survey, cited under F636, revealed that the facility's QAPI committee failed to successfully implement their plan to ensure ongoing compliance with regulations regarding timely completion of comprehensive assessments. The facility's plan of correction for a deficiency regarding a failure to ensure that MDS assessments were accurate upon submission, cited during the survey ending February 14, 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 was	F 0867		

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F 0867 SS=E	Continued from page 144 ineffective in correcting deficient practices related to accurate MDS assessments. The facility's plan of correction for a deficiency regarding the development of a comprehensive person-centered care plan, cited during a survey ending February 14, 2024, revealed that audits would be completed. The results of the current survey, cited under F656, revealed that the QAPI committee was ineffective in correcting deficient practices related to the development of a comprehensive person-centered care plan. The facility's plan of correction for a deficiency regarding professional nursing services, cited during the survey ending February 14, 2024, revealed that the facility would complete audits and report the results of the audits to the QAPI committee for review. The results of the current survey, cited under F658, revealed that the facility's QAPI committee failed to successfully implement their plan to ensure ongoing compliance with regulations regarding professional nursing services.	F 0867		

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F 0867 SS=E	Continued from page 145 The facility's plans of correction for deficiencies regarding providing a safe environment free of accident hazards, cited during the surveys ending February 14 and August 1, 2024 revealed that the facility developed plans 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 F689, revealed that the facility's QAPI committee was ineffective in correcting deficient practices related to safety and accident-free environments. The facility's plans of correction for deficiencies regarding the failure to account for the physician and certified registered nurse practitioner (CRNP) writing progress notes with each visit, cited during the surveys ending February 14, 2024, revealed that the facility would complete audits and the results would be reviewed as part of quality assurance. The results of the current survey, cited under F711, revealed that the facility's QAPI committee was ineffective in correcting deficient practices related to	F 0867		

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	395828	A. BLDG: __00_____ B. WING: _____	01/30/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
MAPLE HEIGHTS HEALTH & REHAB CENTER STATE LICENSE NUMBER: **030202**	**429 MANOR DRIVE EBENSBURG, PA 15931**

(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 0867 SS=E	Continued from page 146 the physician and the CRNP writing progress notes with each visit. The facility's plans of correction for deficiencies regarding the failure to account for controlled medications, cited during the surveys ending February 14, 2024, revealed that the facility would complete audits and the results would be reviewed as part of quality assurance. The results of the current survey, cited under F755, revealed that the facility's QAPI committee was ineffective in correcting deficient practices related to the accountability of controlled medications. The facility's plan of correction for a deficiency regarding storing/labeling medications properly, cited during the survey ending February 14, 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 F761, revealed that the facility's QAPI committee was ineffective in correcting	F 0867		

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F 0867 SS=E	Continued from page 147 deficient practices related to storing/labeling medications properly. The facility's plans of correction for deficiencies regarding infection control practices, cited during the surveys ending February 14 and June 20, 2024, revealed that the facility would complete audits and the results would be reviewed as part of quality assurance. The results of the current survey, cited under F880, revealed that the facility's QAPI committee was ineffective in correcting deficient practices related to infection control. Refer to F600, F636, F641, F656, F658, F689, F711, F755, F761, F880. 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 148 483.80(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	Preparation and submission of this Plan Of Correction (POC) is required by state and federal law. This POC does not constitute an admission for purposes of general liability, professional malpractice or any other court proceeding Resident #79 did not have any adverse reactions. There were no other issues identified at the time of the survey. To prevent a future occurrence, the Director of Nursing/designee will educate nursing staff on the proper use of personal protective equipment and when to use it. To monitor and maintain ongoing compliance, the director of nursing/designee will complete an audit weekly x4 and then monthly x2 to ensure staff is wearing the proper personal protective equipment. Results of audits will be forwarded to facility's Quality Assurance and	Completion Date: **03/17/2025** Status: **APPROVED** Date: **02/20/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0880 SS=D	Continued from page 149 (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	Process Improvement committee for review upon completion for review and recommendations.	

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F 0880 SS=D	Continued from page 150	F 0880		

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F 0880 SS=D	Continued from page 151 Based on review of established infection control guidelines, facility policy, and residents' clinical records, as well as observations and staff interviews, it was determined that the facility failed to follow infection control guidelines from the Centers for Medicare/Medicaid Services (CMS) and the Centers for Disease Control (CDC) to reduce the spread of infections and prevent cross-contamination for one of 66 residents reviewed (Resident 79). Findings include: CDC guidance on isolation precautions and Implementation of Personal Protective Equipment (PPE) use in Nursing Homes to Prevent Spread of Multidrug-Resistant Organisms (MDRO's - bacteria that have become resistant to certain antibiotics, and these antibiotics can no longer be used to control or kill the bacteria), dated July 12, 2022, indicates that MDRO transmission is common in skilled nursing facilities, contributing to substantial resident	F 0880		

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F 0880 SS=D	Continued from page 152 morbidity and mortality and increased healthcare costs. Enhanced Barrier Precautions (EBP's) are an infection control intervention designed to reduce transmission of resistant organisms that employs targeted gown and glove use during high contact resident care activities. CMS updated its infection prevention and control guidance effective April 1, 2024. The recommendations now include the use of EBP's during high-contact care activities for residents with chronic wounds or indwelling medical devices, regardless of their MDRO status, in addition to residents who have an infection or colonization with a CDC-targeted or other epidemiologically important MDRO when contact precautions do not apply. The facility's policy regarding EBP's, dated December 30, 2024, indicated that EBP's are infection control interventions designed to reduce the transmission of MDRO's through gown and glove use by HCP in the long-term care settings in accordance with CDC's consideration for use of EBP in skilled nursing facilities. EBP are	F 0880		

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F 0880 SS=D	Continued from page 153 recommended during high contact care (e.g. dressing, bathing, transferring, changing brief or assisting with toileting, device care, wound care, ect.) activities with residents who are at high risk of acquiring or spreading an MDRO (e.g. residents with indwelling medical devices or wounds). A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 79, dated November 21, 2024, revealed that the resident was understood, could understand others, had a indwelling catheter (a thin, flexible tube inserted into the urinary bladder to collect and drain urine), and had a diagnosis of quadriplegia (a condition characterized by the partial or complete loss of motor function, sensation, and autonomic control in all four limbs (arms and legs)). Physician's orders for Resident 79, dated December 29, 2024, included an order for the resident to be on EBP's. Observations of Resident 79's room on January 27,	F 0880		

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F 0880 SS=D	Continued from page 154 2025, at 10:29 a.m. revealed that there was signage on the resident's door indicating that the resident was on EBP's and that staff was to wear gloves and gown for the following high contact resident care activities: dressing, bathing showering, transferring, changing linens, changing briefs or assisting with toileting, direct care or use central line (a flexible tube inserted into a large vein near the heart), urinary catheter, feeding tube, tracheostomy (a surgical procedure that creates an opening (stoma) in the front of the neck into the trachea (windpipe)), wound care, and any skin opening requiring a dressing. Observations on January 28, 2025, at 11:54 a.m. revealed that Nurse Aide 11 was at Resident 79's bedside emptying the resident's indwelling catheter drainage bag into a clear plastic container. However, while emptying the resident's indwelling catheter drainage bag, she only wore gloves and did not wear a gown. She then performed hand hygiene, placed gloves on, and then assisted the resident to reposition in bed.	F 0880		

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F 0880 SS=D	Continued from page 155 Interview with Licensed Practical Nurse/Infection Control Preventionist on January 28, 2025, at 12:17 p.m. confirmed that Resident 79 was on EBP, and that Nurse Aide 11 should have been wearing a gown and gloves while emptying the resident's indwelling catheter drainage bag and while assisting the resident to reposition in bed. 28 Pa. Code 201.14(a) Responsibility of Licensee. 28 Pa. Code 201.18(e)(1) Management. 28 Pa. Code 211.12(d)(1)(5) Nursing Services.	F 0880		
F 0908 SS=E		F 0908		

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F 0908 SS=E	Continued from page 156 483.90(d)(2) Essential Equipment, Safe Operating Condition §483.90(d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by:	F 0908	Preparation and submission of this Plan of Correction (POC) is required by state and federal law. This POC does not constitute an admission for purposes of general liability, professional malpractice or any other court proceeding No residents had any adverse reactions. To prevent a future occurrence, the Administrator/designee will work with Maintenance staff on the processing repair orders to assure kitchen equipment repairs are fixed timely. Work orders have been initiated for the equipment listed in deficiency. To monitor and maintain ongoing compliance, the Maintenance Director/designee will complete an audit weekly x4 and then monthly x2 to ensure kitchen equipment parts have been ordered, then internally fixed or vendor has fixed the equipment.	Completion Date: **03/17/2025** Status: **APPROVED** Date: **02/20/2025**

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F 0908 SS=E	Continued from page 157	F 0908	Results of audits will be forwarded to facility's Quality Assurance and Process Improvement committee for review upon completion for review and recommendations.	

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 0908 SS=E	Continued from page 158 Based on observations and staff interviews, it was determined that the facility failed to ensure that essential equipment was in safe operating condition in the facility's kitchen. Findings include: Observations in the facility's kitchen on January 29, 2025, at 9:38 a.m. revealed that the first rinse cycle on the dishwashing machine was not registering a temperature during dishwashing and that water was leaking onto the floor from underneath the dishwasher. A steam kettle with a plastic bucket underneath it was catching water that was leaking. Interview with the Dietary Manager on January 30, 2024, at 11:15 a.m. revealed that the dishwasher was washing dishes correctly and providing the final sanitizing rinse that was required; however, it had been leaking water and not properly functioning to full capacity since September 2024. The Dietary Manager also revealed that the steam kettle has	F 0908		

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F 0908 SS=E	Continued from page 159 been broken since June 2024 and needs a new seal; an upright cooler has been out of service since May 2024; the garbage disposal was not being used because it was making a loud noise when turning it on; one oven was not in use since March 2024 because the door pin snapped off; the second oven had a broken on/off switch but was able to be used; one of the two pressure cookers has been out of service because of a bad element since August 2024; and the second pressure cooker has been broken and unable to be repaired since September 2024. Alternate cooking equipment was being used in place of the steamers, and there has been no adverse effects on the meal service related to the broken equipment. Interview with the Nursing Home Administrator on January 30, 2025, at 12:36 p.m. confirmed that the above-mentioned kitchen equipment was not operating properly or not operating at all, and that the facility was in the process of repairing or replacing the kitchen equipment that was not operating correctly.	F 0908		

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F 0908 SS=E	Continued from page 160 28 Pa. Code 201.18(b)(3) Administrator's Responsibility.	F 0908		

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P 1020		P 1020		

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

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P 1020	Continued from page 1 Responsibility of licensee. (a) The licensee is responsible for meeting the minimum standards for the operation of a facility as set forth by the Department and by other Federal, State and local agencies responsible for the health and welfare of residents. This includes complying with all applicable Federal and State laws, and rules, regulations and orders issued by the Department and other Federal, State or local agencies. This REGULATION is not met as evidenced by:	P 1020	Preparation and submission of this Plan oof Correction (POC) is required by state and federal law. This POC does not constitute an admission for purposes of general liability, professional malpractice or any other court proceeding The facility cannot go back and correct previously held infection control meeting. There were no other issues at the time of the survey. To prevent a future occurrence, the Regional Director of Clinical Services educated the Infection Control Nurse and Director of Nursing on Act 52. To monitor and maintain ongoing compliance, the facility will have a community member present at infection control meetings quarterly. A lab member will attend a quarterly meeting. Results of audits will be forwarded	Completion Date: **03/17/2025** Status: **APPROVED** Date: **02/20/2025**

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MAPLE HEIGHTS HEALTH & REHAB CENTER STATE LICENSE NUMBER: **030202**	**429 MANOR DRIVE EBENSBURG, PA 15931**

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P 1020	Continued from page 2	P 1020	to facility's Quality Assurance and Process Improvement committee for review upon completion for review and recommendations.	

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 1020	Continued from page 3 Based on review of Pennsylvania state law, as well as staff interviews, it was determined that the facility failed to ensure that the multi-disciplinary infection control committee met at least quarterly. Findings include: The Act 52 Infection Control Plan, dated January 25, 2024, revealed that a health care facility should develop and implement an internal infection control plan that should be established for the purpose of improving the health and safety of residents and health care workers, and should include a multi-disciplinary committee including a representative from each of the following, if applicable to the specific health care facility. Applicable members included medical staff that could include the chief medical officer or the nursing home medical director, the nursing home administrator, laboratory personnel, nursing staff that could include the director of nursing or a nursing supervisor, pharmacy staff, physical plant personnel,	P 1020		

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P 1020	Continued from page 4 a patient safety officer, and a community member that may not be an agent, employee, or contractor of the facility. As of January 30, 2025, the facility was unable to provide documented evidence that the facility's multi-disciplinary infection control committee had the required laboratory personnel or community member present at least quarterly. Interview with the Infection Preventionist on January 30, 2025, at 1:38 p.m. confirmed that there was no documented evidence that the facility's multi-disciplinary infection control committee had the laboratory personnel or community member present, either in person or on the phone.	P 1020		
P 5380		P 5380		

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P 5380	Continued from page 5 Resident care policies. (d) The policies shall be designed and implemented to ensure that the resident receives proper care to prevent pressure sores and deformities; that the resident is kept comfortable, clean and well-groomed; that the resident is protected from accident, injury and infection; and that the resident is encouraged, assisted and trained in self-care and group activities. This REGULATION is not met as evidenced by:	P 5380	Preparation and submission of this Plan of Correction (POC) is required by state and federal law. This POC does not constitute an admission for purposes of general liability, professional malpractice or any other court proceeding The facility will not be creating a policy pertaining to leg rests. There were no other issues at the time of the survey. To prevent a future occurrence, the Director of Nursing/designee provided education to staff on the seating and positioning policy. The education included the use of wheelchair leg rest for transport. To monitor and maintain ongoing compliance, the Director of Nursing/designee will complete an audit weekly x4 then monthly x2 to ensure staff transporting residents are utilizing leg rests. Results of audits will be forwarded	Completion Date: **03/17/2025** Status: **APPROVED** Date: **02/21/2025**

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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P 5380	Continued from page 6	P 5380	to facility's Quality Assurance and Process Improvement committee for review upon completion for review and recommendations.	

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 5380	Continued from page 7 Based on observations, clinical record reviews, and staff interviews, it was determined that the facility failed to ensure that there was a written policy in place for the use of foot rests on wheelchairs during transportation. Findings include: Observations of Resident 64 on January 27, 2025, at 10:35 a.m. revealed that the resident was transported in her chair by Nurse Aide 8 from her bedroom to the small activity room on the fourth floor with no foot rests on her chair. An interview with Nurse Aide 8 at the time of the observation revealed that she did not apply leg rests to Resident 64's chair prior to transporting the resident and she should have. Observations of Resident 120 on January 27, 2025, at 10:05 a.m. revealed that the resident was transported on her chair from the activity room at the end of the hall to the area in front of the nurses'	P 5380		

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P 5380	Continued from page 8 station by Licensed Practical Nurse 9 with no leg rests on her chair. An interview with Licensed Practical Nurse 9 at the time of the observation revealed that she transported the resident because she was being disruptive to other residents and that she did not apply leg rests prior to transporting her. Interview with the Director of Nursing on January 28, 2025, at 1:37 p.m. confirmed that the facility did not have a policy regarding the use of foot rests on wheelchairs for transportation.	P 5380		
P 5520		P 5520		

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P 5520	Continued from page 9 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	Preparation and submission of this Plan of Correction (POC) is required by state and federal law. This POC does not constitute an admission for purposes of general liability, professional malpractice or any other court proceeding The facility cannot retroactively correct past staffing issues. To prevent a future occurrence, the scheduler will be reeducated on staffing nurse aides to include expectations of Hours Per Patient Day and ratios by the director of nursing/designee. The facility will hold staffing meetings 5 days per week, consisting of the Nursing Home Administrator, Director of Nursing, Human Resources and scheduler to review ratio compliance for upcoming schedules. During staffing meeting discussion will be held on efforts to fill open slots to meet ratio by contacting external agencies for staff and asking in house staff to cover additional shifts.	Completion Date: **03/17/2025** Status: **APPROVED** Date: **02/21/2025**

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P 5520	Continued from page 10	P 5520	To monitor and maintain ongoing compliance, the Director of Nursing/designee will monitor nurse aide hours 5 days a week and ongoing to ensure compliance. Ad hoc education will be provided as needed. Results of audits will be forwarded to facility's Quality Assurance and Process Improvement committee for review upon completion for review and recommendations.	

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P 5520	Continued from page 11 Based on review of nursing schedules and staffing information furnished by the facility, as well as staff interview, it was determined that the facility failed to ensure a minimum of one nurse aide (NA) per 10 residents on the day shift for 16 of 21 days reviewed for January 5 through 11, January 12 through 18, and January 23 through 29, 2025; to ensure a minimum of one NA per 11 residents on the evening shift for 11 of 21 days reviewed for January 5 through 11, January 12 through 18, and January 23 through 29, 2025; and failed to ensure a minimum of one NA per 15 residents on the overnight shift for 18 of 21 days reviewed for January 5 through 11, January 12 through 18, and January 23 through 29, 2025. Findings include: Review of facility census data indicated that on January 6, 2025, the facility census was 156, which required 15.60 NA's during the day shift. Review of the nursing time schedules revealed 12.59 NA's	P 5520		

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P 5520	Continued from page 12 provided care on the day shift on January 6, 2025. Review of facility census data indicated that on January 7, 2025, the facility census was 159, which required 15.90 NA's during the day shift. Review of the nursing time schedules revealed 12.13 NA's provided care on the day shift on January 7, 2025. Review of facility census data indicated that on January 10, 2025, the facility census was 156, which required 15.60 NA's during the day shift. Review of the nursing time schedules revealed 15.08 NA's provided care on the day shift on January 10, 2025. Review of facility census data indicated that on January 11, 2025, the facility census was 155 which required 15.50 NA's during the day shift. Review of the nursing time schedules revealed 12.31 NA's provided care on the day shift on January 11, 2025. Review of facility census data indicated that on January 12, 2025, the facility census was 154, which required 15.40 NA's during the day shift. Review of the nursing time schedules revealed 12.13 NA's provided care on the day shift on January 12, 2025. Review of facility census data indicated that on January 15, 2025, the facility census was 154,	P 5520		

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P 5520	Continued from page 13 which required 15.40 NA's during the day shift. Review of the nursing time schedules revealed 13.94 NA's provided care on the day shift on January 15, 2025. Review of facility census data indicated that on January 16, 2025, the facility census was 150, which required 15.00 NA's during the day shift. Review of the nursing time schedules revealed 12.06 NA's provided care on the day shift on January 16, 2025. Review of facility census data indicated that on January 17, 2025, the facility census was 156, which required 15.60 NA's during the day shift. Review of the nursing time schedules revealed 14.00 NA's provided care on the day shift on January 17, 2025. Review of facility census data indicated that on January 18, 2025, the facility census was 156, which required 15.60 NA's during the day shift. Review of the nursing time schedules revealed 14.03 NA's provided care on the day shift on January 18, 2025. Review of facility census data indicated that on January 23, 2025, the facility census was 161, which required 16.10 NA's during the day shift. Review of the nursing time schedules revealed 15.97 NA's provided care on the day shift on January 23,	P 5520		

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P 5520	Continued from page 14 2025. Review of facility census data indicated that on January 24, 2025, the facility census was 161, which required 16.10 NA's during the day shift. Review of the nursing time schedules revealed 15.13 NA's provided care on the day shift on January 24, 2025. Review of facility census data indicated that on January 25, 2025, the facility census was 157, which required 15.70 NA's during the day shift. Review of the nursing time schedules revealed 15.34 NA's provided care on the day shift on January 25, 2025. Review of facility census data indicated that on January 26, 2025, the facility census was 157, which required 15.70 NA's during the day shift. Review of the nursing time schedules revealed 13.03 NA's provided care on the day shift on January 26, 2025. Review of facility census data indicated that on January 27, 2025, the facility census was 159, which required 15.90 NA's during the day shift. Review of the nursing time schedules revealed 13.03 NA's provided care on the day shift on January 27, 2025. Review of facility census data indicated that on January 28, 2025, the facility census was 157, which required 15.70 NA's during the day shift.	P 5520		

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P 5520	Continued from page 15 Review of the nursing time schedules revealed 13.97 NA's provided care on the day shift on January 28, 2025. Review of facility census data indicated that on January 29, 2025, the facility census was 157, which required 15.70 NA's during the day shift. Review of the nursing time schedules revealed 15.13 NA's provided care on the day shift on January 29, 2025. Review of facility census data indicated that on January 5, 2025, the facility census was 156, which required 14.18 NA's during the evening shift. Review of the nursing time schedules revealed 13.28 NA's provided care on the evening shift on January 5, 2025. Review of facility census data indicated that on January 7, 2025, the facility census was 159, which required 14.45 NA's during the evening shift. Review of the nursing time schedules revealed 13.56 NA's provided care on the evening shift on January 7, 2025. Review of facility census data indicated that on January 8, 2025, the facility census was 157, which required 14.27 NA's during the evening shift. Review of the nursing time schedules revealed 12.97	P 5520		

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P 5520	Continued from page 16 NA's provided care on the evening shift on January 8, 2025. Review of facility census data indicated that on January 14, 2025, the facility census was 151, which required 13.73 NA's during the evening shift. Review of the nursing time schedules revealed 13.53 NA's provided care on the evening shift on January 14, 2025. Review of facility census data indicated that on January 15, 2025, the facility census was 154, which required 14.00 NA's during the evening shift. Review of the nursing time schedules revealed 13.47 NA's provided care on the evening shift on January 15, 2025. Review of facility census data indicated that on January 16, 2025, the facility census was 150, which required 13.64 NA's during the evening shift. Review of the nursing time schedules revealed 11.84 NA's provided care on the evening shift on January 16, 2025. Review of facility census data indicated that on January 18, 2025, the facility census was 156, which required 14.18 NA's during the evening shift. Review of the nursing time schedules revealed 12.69 NA's provided care on the evening shift on January 18, 2025. Review of facility census data indicated	P 5520		

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P 5520	Continued from page 17 that on January 23, 2025, the facility census was 161, which required 14.64 NA's during the evening shift. Review of the nursing time schedules revealed 13.75 NA's provided care on the evening shift on January 23, 2025. Review of facility census data indicated that on January 26, 2025, the facility census was 157, which required 14.27 NA's during the evening shift. Review of the nursing time schedules revealed 14.13 NA's provided care on the evening shift on January 26, 2025. Review of facility census data indicated that on January 27, 2025, the facility census was 159, which required 14.45 NA's during the evening shift. Review of the nursing time schedules revealed 13.13 NA's provided care on the evening shift on January 27, 2025. Review of facility census data indicated that on January 29, 2025, the facility census was 157, which required 14.27 NA's during the evening shift. Review of the nursing time schedules revealed 13.41 NA's provided care on the evening shift on January 29, 2025. Review of facility census data indicated that on	P 5520		

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P 5520	Continued from page 18 January 5, 2025, the facility census was 156, which required 10.40 NA's during the overnight shift. Review of the nursing time schedules revealed 8.97 NA's provided care on the overnight shift on January 5, 2025. Review of facility census data indicated that on January 6, 2025, the facility census was 156, which required 10.40 NA's during the overnight shift. Review of the nursing time schedules revealed 9.13 NA's provided care on the overnight shift on January 6, 2025. Review of facility census data indicated that on January 7, 2025, the facility census was 159, which required 10.60 NA's during the overnight shift. Review of the nursing time schedules revealed 10.06 NA's provided care on the overnight shift on January 7, 2025. Review of facility census data indicated that on January 8, 2025, the facility census was 157, which required 10.47 NA's during the overnight shift. Review of the nursing time schedules revealed 9.13 NA's provided care on the overnight shift on January 8, 2025. Review of facility census data indicated that on January 9, 2025, the facility census was 157, which required 10.47 NA's during the overnight	P 5520		

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(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 5520	Continued from page 19 shift. Review of the nursing time schedules revealed 9.94 NA's provided care on the overnight shift on January 9, 2025. Review of facility census data indicated that on January 11, 2025, the facility census was 155, which required 10.33 NA's during the overnight shift. Review of the nursing time schedules revealed 10.09 NA's provided care on the overnight shift on January 11, 2025. Review of facility census data indicated that on January 12, 2025, the facility census was 154, which required 10.27 NA's during the overnight shift. Review of the nursing time schedules revealed 9.16 NA's provided care on the overnight shift on January 12, 2025. Review of facility census data indicated that on January 13, 2025, the facility census was 150, which required 10.00 NA's during the overnight shift. Review of the nursing time schedules revealed 9.63 NA's provided care on the overnight shift on January 13, 2025. Review of facility census data indicated that on January 15, 2025, the facility census was 154, which required 10.27 NA's during the overnight shift. Review of the nursing time schedules revealed 9.59 NA's provided care on the	P 5520		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395828	A. BLDG: 00 B. WING:	01/30/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
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P 5520	Continued from page 20 overnight shift on January 15, 2025. Review of facility census data indicated that on January 16, 2025, the facility census was 150, which required 10.00 NA's during the overnight shift. Review of the nursing time schedules revealed 8.88 NA's provided care on the overnight shift on January 16, 2025. Review of facility census data indicated that on January 18, 2025, the facility census was 161, which required 10.40 NA's during the overnight shift. Review of the nursing time schedules revealed 9.38 NA's provided care on the overnight shift on January 18, 2025. Review of facility census data indicated that on January 23, 2025, the facility census was 161, which required 10.73 NA's during the overnight shift. Review of the nursing time schedules revealed 10.38 NA's provided care on the overnight shift on January 23, 2025. Review of facility census data indicated that on January 24, 2025, the facility census was 161, which required 10.73 NA's during the overnight shift. Review of the nursing time schedules revealed 9.88 NA's provided care on the overnight shift on January 24, 2025. Review of facility census data indicated that	P 5520		

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 21 on January 25, 2025, the facility census was 157, which required 10.47 NA's during the overnight shift. Review of the nursing time schedules revealed 9.63 NA's provided care on the overnight shift on January 25, 2025. Review of facility census data indicated that on January 26, 2025, the facility census was 157, which required 10.47 NA's during the overnight shift. Review of the nursing time schedules revealed 8.53 NA's provided care on the overnight shift on January 26, 2025. Review of facility census data indicated that on January 27, 2025, the facility census was 159, which required 10.60 NA's during the overnight shift. Review of the nursing time schedules revealed 8.63 NA's provided care on the overnight shift on January 27, 2025. Review of facility census data indicated that on January 28, 2025, the facility census was 157, which required 10.47 NA's during the overnight shift. Review of the nursing time schedules revealed 9.88 NA's provided care on the overnight shift on January 28, 2025. Review of facility census data indicated that on January 29, 2025, the facility census was 157, which required 10.47 NA's during	P 5520		

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 22 the overnight shift. Review of the nursing time schedules revealed 9.59 NA's provided care on the overnight shift on January 29, 2025. No additional excess higher-level staff were available to compensate for these deficiencies. Interview with the Nursing Home Administrator on January 30, 2025, at 3:10 p.m. confirmed that the facility did not meet the required NA-to-resident staffing ratios for the days listed above.	P 5520		
P 5530		P 5530		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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P 5530	Continued from page 23 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	Preparation and submission of this Plan of Correction (POC) is required by state and federal law. This POC does not constitute an admission for purposes of general liability, professional malpractice or any other court proceeding The facility cannot retroactively correct past staffing issues. To prevent a future occurrence, the scheduler will be reeducated on staffing licensed practical nurses to include expectations of Hours Per Patient Day and ratios by the director of nursing/designee. The facility will hold staffing meetings 5 days per week, consisting of the Nursing Home Administrator, Director of Nursing, Human Resources and scheduler to review ratio compliance for upcoming schedules. During staffing meeting discussion will be held on efforts to fill open slots to meet ratio by contacting external agencies for staff and asking in house staff to cover additional shifts.	Completion Date: **03/17/2025** Status: **APPROVED** Date: **02/21/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395828	A. BLDG: __00_____ B. WING: _____	01/30/2025

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P 5530	Continued from page 24	P 5530	To monitor and maintain ongoing compliance, the Director of Nursing/designee will monitor licensed practical nurse hours 5 days a week and ongoing to ensure compliance. Ad hoc education will be provided as needed. Results of audits will be forwarded to facility's Quality Assurance and Process Improvement committee for review upon completion for review and recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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P 5530	Continued from page 25 Based on a review of nursing schedules, staffing information provided by the facility, and staff interviews, it was determined that the facility failed to ensure a minimum of one licensed practical nurse (LPN) per 25 residents on the day shift for four of 14 days reviewed for January 5 through 11, and January 12 through 18, 2025; failed to ensure a minimum of one LPN per 30 residents on the evening shift for 10 of 21 days reviewed for January 5 through 11, January 12 through 18, 2025, and January 23 through 29, 2025; and failed to ensure a minimum of one LPN per 40 residents on the overnight shift for 13 of 21 days reviewed for January 5 through 11, January 12 through 18, 2025, and January 23 through 29, 2025. Findings Include: Review of facility census data indicated that on indicated that on January 8, 2025, the facility census was 157, which required 6.28 LPN's during the day shift. Review of the nursing time schedules revealed	P 5530		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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P 5530	Continued from page 26 6.19 LPN's provided care on the day shift on January 8, 2025. Review of facility census data indicated that on indicated that on January 10, 2025, the facility census was 156, which required 6.24 LPN's during the day shift. Review of the nursing time schedules revealed 5.91 LPN's provided care on the day shift on January 10, 2025. Review of facility census data indicated that on indicated that on January 11, 2025, the facility census was 155, which required 6.20 LPN's during the day shift. Review of the nursing time schedules revealed 5.66 LPN's provided care on the day shift on January 11, 2025. Review of facility census data indicated that on indicated that on January 12, 2025, the facility census was 154, which required 6.16 LPN's during the day shift. Review of the nursing time schedules revealed 6.03 LPN's provided care on the day shift on January 12, 2025. Review of facility census data indicated that on indicated that on January 5, 2025, the facility census was 156, which required 5.20 LPN's during the evening shift. Review of the nursing time schedules	P 5530		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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P 5530	Continued from page 27 revealed 5.16 LPN's provided care on the evening shift on January 5, 2025. Review of facility census data indicated that on indicated that on January 6, 2025, the facility census was 156, which required 5.20 LPN's during the evening shift. Review of the nursing time schedules revealed 4.00 LPN's provided care on the evening shift on January 6, 2025. Review of facility census data indicated that on indicated that on January 8, 2025, the facility census was 157, which required 5.23 LPN's during the evening shift. Review of the nursing time schedules revealed 5.13 LPN's provided care on the evening shift on January 8, 2025. Review of facility census data indicated that on indicated that on January 8, 2025, the facility census was 157, which required 5.23 LPN's during the evening shift. Review of the nursing time schedules revealed 3.88 LPN's provided care on the evening shift on January 9, 2025. Review of facility census data indicated that on indicated that on January 12, 2025, the facility census was 154, which required 5.13 LPN's during the evening shift. Review of the nursing time schedules revealed 3.94 LPN's provided care on	P 5530		

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P 5530	Continued from page 28 the evening shift on January 12, 2025. Review of facility census data indicated that on indicated that on January 17, 2025, the facility census was 150, which required 3.75 LPN's during the evening shift. Review of the nursing time schedules revealed 2.44 LPN's provided care on the evening shift on January 17, 2025. Review of facility census data indicated that on indicated that on January 23, 2025, the facility census was 161, which required 5.37 LPN's during the evening shift. Review of the nursing time schedules revealed 4.50 LPN's provided care on the evening shift on January 23, 2025. Review of facility census data indicated that on indicated that on January 25, 2025, the facility census was 157, which required 5.23 LPN's during the evening shift. Review of the nursing time schedules revealed 5.00 LPN's provided care on the evening shift on January 25, 2025. Review of facility census data indicated that on indicated that on January 26, 2025, the facility census was 157, which required 5.23 LPN's during the evening shift. Review of the nursing time schedules revealed 5.06 LPN's provided care on the evening shift on January 26, 2025. Review of	P 5530		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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P 5530	Continued from page 29 facility census data indicated that on indicated that on January 29, 2025, the facility census was 157, which required 5.23 LPN's during the evening shift. Review of the nursing time schedules revealed 4.59 LPN's provided care on the evening shift on January 29, 2025. Review of facility census data indicated that on indicated that on January 6, 2025, the facility census was 156, which required 3.90 LPN's during the overnight shift. Review of the nursing time schedules revealed 2.03 LPN's provided care on the overnight shift on January 6, 2025. Review of facility census data indicated that on indicated that on January 7, 2025, the facility census was 159, which required 3.98 LPN's during the overnight shift. Review of the nursing time schedules revealed 3.94 LPN's provided care on the overnight shift on January 7, 2025. Review of facility census data indicated that on indicated that on January 8, 2025, the facility census was 157, which required 3.93 LPN's during the overnight shift. Review of the nursing time schedules revealed 3.00 LPN's provided care on	P 5530		

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P 5530	Continued from page 30 the overnight shift on January 8, 2025. Review of facility census data indicated that on indicated that on January 9, 2025, the facility census was 157, which required 3.93 LPN's during the overnight shift. Review of the nursing time schedules revealed 3.03 LPN's provided care on the overnight shift on January 9, 2025. Review of facility census data indicated that on indicated that on January 11, 2025, the facility census was 155, which required 3.88 LPN's during the overnight shift. Review of the nursing time schedules revealed 3.50 LPN's provided care on the overnight shift on January 11, 2025. Review of facility census data indicated that on indicated that on January 12, 2025, the facility census was 154, which required 3.85 LPN's during the overnight shift. Review of the nursing time schedules revealed 1.53 LPN's provided care on the overnight shift on January 12, 2025. Review of facility census data indicated that on indicated that on January 14, 2025, the facility census was 151, which required 3.78 LPN's during the overnight shift. Review of the nursing time schedules revealed 3.00 LPN's provided care on the overnight shift on	P 5530		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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P 5530	Continued from page 31 January 14, 2025. Review of facility census data indicated that on indicated that on January 16, 2025, the facility census was 150, which required 3.75 LPN's during the overnight shift. Review of the nursing time schedules revealed 2.44 LPN's provided care on the overnight shift on January 16, 2025. Review of facility census data indicated that on indicated that on January 23, 2025, the facility census was 161, which required 4.03 LPN's during the overnight shift. Review of the nursing time schedules revealed 4.00 LPN's provided care on the overnight shift on January 23, 2025. Review of facility census data indicated that on indicated that on January 25, 2025, the facility census was 157, which required 3.93 LPN's during the overnight shift. Review of the nursing time schedules revealed 3.00 LPN's provided care on the overnight shift on January 25, 2025. Review of facility census data indicated that on indicated that on January 26, 2025, the facility census was 157, which required 3.93 LPN's during the overnight shift. Review of the nursing time schedules revealed 3.47 LPN's provided care on the overnight shift on January 26,	P 5530		

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P 5530	Continued from page 32 2025. Review of facility census data indicated that on indicated that on January 28, 2025, the facility census was 157, which required 3.93 LPN's during the overnight shift. Review of the nursing time schedules revealed 3.56 LPN's provided care on the overnight shift on January 28, 2025. Review of facility census data indicated that on indicated that on January 29, 2025, the facility census was 157, which required 3.93 LPN's during the overnight shift. Review of the nursing time schedules revealed 3.50 LPN's provided care on the overnight shift on January 29, 2025. No additional excess higher-level staff were available to compensate for this deficiency. Interview with the Nursing Home Administrator on January 30, 2025, at 3:10 p.m. confirmed that the facility did not meet the required LPN-to-resident staffing ratios for the days listed above.	P 5530		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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P 5640		P 5640		

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P 5640	Continued from page 34 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	Preparation and submission of this Plan of Correction (POC) is required by state and federal law. This POC does not constitute an admission for purposes of general liability, professional malpractice or any other court proceeding The facility cannot retroactively correct past staffing issues. To prevent a future occurrence, the scheduler will be reeducated on staffing Per Patient Day (PPD) to include expectations of Hours Per Patient Day and ratios by the director of nursing/designee. The facility will hold staffing meetings 5 days per week, consisting of the Nursing Home Administrator, Director of Nursing, Human Resources and scheduler to review ratio and PPD compliance for upcoming schedules. During staffing meeting discussion will be held on efforts to fill open slots to meet Hours Per Patient Day by contacting external agencies for staff and asking in house staff to cover	Completion Date: **03/17/2025** Status: **APPROVED** Date: **02/21/2025**

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P 5640	Continued from page 35	P 5640	additional shifts. To monitor and maintain ongoing compliance, the Director of Nursing/designee will monitor PPD hours 5 days a week and ongoing to ensure compliance. Ad hoc education will be provided as needed. Results of audits will be forwarded to facility's Quality Assurance and Process Improvement committee for review upon completion for review and recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395828	A. BLDG: 00 B. WING:	01/30/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
MAPLE HEIGHTS HEALTH & REHAB CENTER STATE LICENSE NUMBER: **030202**	**429 MANOR DRIVE** **EBENSBURG, PA 15931**

(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 36 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 17 of 21 days (24-hour periods) reviewed. Findings include: Nursing time schedules provided by the facility for the days of January 5 through 11, January 12 through 18, and January 23 through 29, 2025, revealed that the facility provided only 3.13 hours of direct care for each resident on January 5, 2025; 2.87 hours of direct care for each resident on January 6, 2025; 3.01 hours of direct care for each resident on January 7, 2025; 3.02 hours of direct care for each resident on January 8, 2025; 3.12 hours of direct care for each resident on January 10, 2025; 3.00 hours of direct care for each resident on January 11, 2025; 2.91 hours of direct care for each resident on January 12, 2025; 3.14 hours of direct care for each resident on January 15, 2025;	P 5640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395828	A. BLDG: __00_____ B. WING: _____	01/30/2025

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P 5640	Continued from page 37 2.96 hours of direct care for each resident on January 16, 2025; 3.09 hours of direct care for each resident on January 17, 2025; 3.04 hours of direct care for each resident on January 18, 2025; 3.07 hours of direct care for each resident on January 23, 2025; 3.14 hours of direct care for each resident on January 24, 2025; 3.03 hours of direct care for each resident on January 25, 2025; 2.83 hours of direct care for each resident on January 26, 2025; 3.04 hours of direct care for each resident on January 27, 2025; and 3.02 hours of direct care for each resident on January 29, 2025. Interview with the Nursing Home Administrator on January 30, 2025, at 3:10 p.m. confirmed that the facility did not meet the required daily direct resident care hours on the days listed above.	P 5640		

Certified End Page

MAPLE HEIGHTS HEALTH & REHAB CENTER

STATE LICENSE NUMBER: 030202

SURVEY EXIT DATE: 01/30/2025

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

Jeanne Parisi
Deputy Secretary for Quality Assurance

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

Pennsylvania
Department of Health

THIS IS A CERTIFICATION PAGE

PLEASE DO NOT DETACH

THIS PAGE IS NOW PART OF THIS SURVEY