

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395840	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/09/2025
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NAME OF PROVIDER OR SUPPLIER: PATRIOT VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE: 495 WEST PATRIOT STREET SOMERSET, PA 15501
STATE LICENSE NUMBER: 167902	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0000	INITIAL COMMENT	F 0000		
F 0550 SS=D	Based on a Medicare/Medicaid Recertification survey, State Licensure survey, and Civil Rights Compliance survey completed on January 9, 2025, it was determined that Patriot Village 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 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	This plan of correction is prepared and executed because it is required by the provisions of the state and federal regulations and not because Patriot Village OPCO LLC agrees with the allegations and citations listed on the statement of deficiencies. Patriot Village OPCO LLC maintains that the alleged deficiencies do not, individually and collectively, jeopardize the health and safety of the residents, nor are they of such character as to limit our capacity to render adequate care as prescribed by regulation. This plan of correction shall operate as Patriot Village OPCO LLC's written credible allegation of compliance. By submitting this plan of correction, Patriot Village OPCO LLC does not admit to the accuracy of the deficiencies. This plan of correction is not meant to establish any standard of care, contract, obligation, or position, and Patriot Village OPCO LLC all rights to raise all possible contentions and defenses in any civil or criminal	Completion Date: 02/20/2025 Status: APPROVED Date: 02/03/2025

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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	claim, action or proceeding. 1. The identified concern for R34 was immediately corrected. 2. The Director of Nursing or designee will audit indwelling urinary catheter bags for an appropriate privacy covering, positioning of the catheter bag and tubing below the level of the bladder. 3. The Director of Nursing or designee will re-educate nursing staff on having an appropriate privacy cover of urinary catheter bags and positioning of the catheter bag and tubing below the level of the bladder 4. The Director of Nursing or designee will audit residents with indwelling urinary catheter bags for the appropriate privacy covering and positioning of the catheter bag and tubing below the level of the bladder. The audits will be conducted weekly x4 and monthly	

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F 0550 SS=D	Continued from page 3	F 0550	x2. All findings will be submitted to the Quality Assurance Committee.	

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F 0550 SS=D	Continued from page 4 Based on review of clinical records, as well as observations and staff interviews, it was determined that the facility failed to maintain dignity for one of 33 residents reviewed (Resident 34) who had an indwelling urinary catheter. Findings include: A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 34, dated December 19, 2024, indicated that the resident was understood and able to understand others, and had an indwelling urinary catheter (a flexible tube used to drain urine from the bladder into a drainage collection bag). A care plan for the resident, dated April 29, 2024, revealed that the resident had an indwelling urinary catheter. Staff were to cover the urinary drainage bag with a dignity cover and position the catheter bag and tubing below the level of the bladder and away from entrance room door.	F 0550		

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F 0550 SS=D	<p>Continued from page 5</p> <p>Physician's orders for Resident 34, dated August 22, 2024, included an order for the resident to have an indwelling urinary catheter for a diagnosis of obstructive uropathy (a condition that occurs when urine is blocked from draining through the urinary tract).</p> <p>Observations of Resident 34 on January 7, 2025, at 10:41 a.m. and 11:33 a.m. revealed that the resident was lying in bed with his indwelling urinary catheter drainage bag hooked to the bedframe on the door side of the bed. The bag was not covered and yellow urine was visible.</p> <p>Interview with Licensed Practical Nurse 1 on January 7, 2025, at 11:34 a.m. confirmed that Resident 34 did not have a dignity (privacy) cover on his indwelling urinary catheter bag and that it was positioned on the door side of the bed.</p> <p>Interview with the Director of Nursing on January 7, 2025, at 2:40 p.m. confirmed that Resident 34's indwelling urinary catheter drainage should have</p>	F 0550		

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F 0550 SS=D	Continued from page 6 been covered with a dignity (privacy) cover. 28 Pa. Code 201.29(c) Resident Rights.	F 0550		
F 0578 SS=D		F 0578		

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F 0578 SS=D	Continued from page 7 483.10(c)(6)(8)(g)(12)(i)-(v) Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance	F 0578	<ol style="list-style-type: none"> 1. The identified concern for R10 and R46 cannot be corrected. The responsible party will be notified of the identified concern. 2. The Director of Nursing or designee will audit current resident's medical records to determine if there is an advanced directive on file. 3. The Director of Nursing or designee will re-educate admission staff on ensuring that the resident and/or resident representative are given the opportunity to develop or decline assistance in formulating an advanced directive. 4. The Director of Nursing or designee will audit new residents medical record for the documented evidence of the resident and/or resident representative decision to accept or decline assistance in formulating advanced directives. The audits will be conducted weekly x4 and monthly x2. All findings will be submitted to the Quality 	Completion Date: 02/20/2025 Status: APPROVED Date: 02/03/2025

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F 0578 SS=D	Continued from page 8 directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by:	F 0578	Assurance Committee.	

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F 0578 SS=D	Continued from page 9 Based on review of facility policies and clinical records, as well as staff interviews, it was determined that the facility failed to ensure that the resident and/or resident representative had an opportunity to develop an advance directive (instructions regarding the provision of health care when the resident is incapacitated) or assist in formulating an advance directive for two of 31 residents reviewed (Residents 10, 46). Findings include: The facility policy regarding advance directives, dated August 28, 2024, indicated that prior to or upon admission of the resident, the social services director or designee inquires of the resident, his/her family members, and/or his or her legal representative about the existence of any written advance directive. The resident or representative is provided with written information concerning the right to refuse or accept medical or surgical treatment and to formulate an advance directive if he	F 0578		

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F 0578 SS=D	Continued from page 10 or she chooses to do so. If the resident or resident representative indicates that he or she has not established advance directives, the facility staff will offer assistance in establishing advance directives. The resident and/or resident representative is given the option to accept or decline assistance. The nursing staff will document in the medical record the offer to assist and the resident's decision to accept or decline assistance. Information about whether or not the resident has executed an advance directive is displayed prominently in the medical record in a section that is retrievable by any staff. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 10, dated December 19, 2024, indicated that the resident was cognitively impaired, was usually understood and usually able to understand others, had severely impaired vision, and was dependent with care needs. An annual MDS assessment for Resident 46, dated October 17, 2024, revealed that the resident was	F 0578		

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F 0578 SS=D	Continued from page 11 cognitively intact, was understood and able to understand others, and required assistance for care needs. Review of Residents 10's and 46's medical records indicated that they did not have advance directives. There was no documented evidence in the residents' clinical records that the residents and/or resident representatives were given the opportunity to develop an advance directive and no documented evidence of the residents' and/or resident representatives' decisions to accept or decline assistance in formulating advanced directives. Interview with the Nursing Home Administrator on January 9, 2025, at 10:39 a.m. confirmed that there was no documented evidence in Resident 10's or Resident 46's clinical records that the residents and/or resident representatives were given the opportunity to develop an advance directive and no documented evidence of the residents' and/or resident representatives' decisions to accept or decline assistance in formulating advanced	F 0578		

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F 0578 SS=D	Continued from page 12 directives. 28 Pa. Code 201.29(a)(d) Resident Rights.	F 0578		
F 0584 SS=D	483.10(i)(1)-(7) Safe/Clean/Comfortable/Homelike Environment §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good	F 0584	1. The identified concern for R19, R69, and R84 will be reviewed and corrected. 2. The Director of Nursing or designee will audit current recliners to determine the need for a slipcover. Chairs that are in bad shape will be discarded and replaced. 3. The Director of Nursing or designee will re-educate staff on the process of utilizing a slipcover, if needed, for on a recliner. 4. The Director of Nursing or designee will audit recliners for usage of a slipcover if needed. The audits will be conducted weekly x4 and monthly x2. All findings will be submitted to the Quality Assurance Committee.	Completion Date: 02/20/2025 Status: APPROVED Date: 02/03/2025

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F 0584 SS=D	Continued from page 13 condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by:	F 0584		

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F 0584 SS=D	Continued from page 14 Based on observations and staff interviews, it was determined that the facility failed to provide a homelike environment for three of 31 residents reviewed (Residents 19, 69, 84). Findings include: Observations of Resident 19 on January 8, 2025, at 8:50 a.m. revealed that the resident was sitting in her room in a facility recliner that had the leather covering on the arms, seat and back of the chair heavily shredded and torn. In order to provide comfort, the resident had her own blanket covering the back of the chair. When asked if she minded the torn upholstery, the resident indicated that she would rather it had a brown slipcover like her roommate's recliner. Observations of Resident 69 on January 7, 2025, at 10:22 a.m. and January 8, 2025, at 8:57 a.m. revealed that the resident was sitting in his room in a facility recliner that had the leather covering on the	F 0584		

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F 0584 SS=D	Continued from page 15 arms, seat and back that was very heavily shredded and torn. Observations of Resident 84's facility recliner on January 8, 2025, at 8:53 revealed that the arms and back of the leather-type covering was shredded and torn. Interview with the Maintenance Supervisor on January 8, 2025, at 9:10 a.m. confirmed that Resident 19's, 69's and 84's recliners should have had slipcovers on them. Interview with the Nursing Home Administrator on January 8, 2025, at 9:16 a.m. confirmed that Resident 19, 69 and 84 are currently using recliner chairs that have the leather covering torn and in some cases heavily shredded. He went on to say that most of the recliners have brown slipcovers on them, but it has been difficult finding more slipcovers to purchase that fit the recliners. The Nursing Home Administrator indicated that the torn/shredded recliners are not homelike and should not be used	F 0584		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0584 SS=D	Continued from page 16 by the residents. 28 Pa. Code 201.29(j) Resident Rights. 28 Pa. Code 207.2(a) Administrator's Responsibility.	F 0584		
F 0623 SS=D		F 0623		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395840	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/09/2025	
NAME OF PROVIDER OR SUPPLIER: PATRIOT VILLAGE STATE LICENSE NUMBER: 167902		STREET ADDRESS, CITY, STATE, ZIP CODE: 495 WEST PATRIOT STREET SOMERSET, PA 15501		
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F 0623 SS=D	Continued from page 17 483.15(c)(3)-(6)(8) Notice Requirements Before Transfer/Discharge §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c) (2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)	F 0623	1. The identified concern for R61 and R73 cannot be corrected. 2. The Director of Nursing or designee will audit the last three months of long term hospital transfers for notification that a written notice for transfer to the hospital was provided to the State Long-Term Care Ombudsman and that that a written notice was provided to the resident and the resident's responsible party regarding the reason for transfer to the hospital for long-term residents. 3. The Director of Nursing or designee will re-educate staff on the process of notification to the State Long-Term Care Ombudsman and providing a written notice to the resident and or resident's responsible party regarding the reason for transfer to the hospital for long-term residents. 4. The Director of Nursing or designee will audit the process of notification to the State Long-Term	Completion Date: 02/20/2025 Status: APPROVED Date: 02/03/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395840	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/09/2025	
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F 0623 SS=D	Continued from page 18 (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	Care Ombudsman and providing a written notice to the resident and or resident's responsible party regarding the reason for transfer to the hospital for long-term residents. The audits will be conducted weekly x4 and monthly x2. All findings will be submitted to the Quality Assurance Committee.	

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F 0623 SS=D	Continued from page 19 (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 20 Based on clinical record reviews and staff interviews, it was determined that the facility failed to ensure that a written notice regarding emergency transfer to the hospital was provided to the Office of the State Long-Term Care Ombudsman, and failed to ensure that a written notice was provided to the resident and the resident's responsible party regarding the reason for transfer to the hospital for two of 31 residents reviewed (Residents 61, 73). Findings include: A significant change Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 61, dated December 6, 2024, indicated that the resident was cognitively intact, was understood, and could understand others. A nursing note, dated November 29, 2024, at 1:18 p.m., revealed that Resident 61 was diaphoretic (sweating), slurring words, and hypoxic. The	F 0623		

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F 0623 SS=D	<p>Continued from page 21</p> <p>resident began to vomit brown liquid and was then sent to the emergency room for evaluation and treatment.</p> <p>There was no documented evidence that a written notice of Resident 61's transfer to the hospital was provided to the State Long-Term Care Ombudsman and that a written notice was provided to the resident and the resident's responsible party regarding the reason for transfer to the hospital.</p> <p>A quarterly MDS assessment for Resident 73, dated November 21, 2024, revealed that the resident was understood, and could understand others.</p> <p>A nursing note for Resident 73, dated December 22, 2024, at 7:03 a.m., revealed that the writer was notified by the licensed practical nurse that the resident's blood pressure was low at 60/40 millimeter of mercury (mmHg) (a normal blood pressure is less than 120/80 mmHg). The resident was pale, diaphoretic (excessive sweating due to a</p>	F 0623		

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F 0623 SS=D	<p>Continued from page 22</p> <p>secondary condition), clammy, with her eyes closed, and she would respond to physical stimuli only. The physician was notified and a new order was received to send the resident to the hospital at this time. A nursing note at 2:26 p.m. revealed that the resident was admitted to the hospital.</p> <p>There was no documented evidence that a written notice of Resident 73's transfer to the hospital was provided to the State Long-Term Care Ombudsman and that a written notice was provided to the resident and the resident's responsible party regarding the reason for transfer to the hospital.</p> <p>Interview with the Director of Nursing on January 8, 2025, at 2:18 p.m. confirmed that there was no documented evidence that a written notice of Resident 61's and 73's transfer to the hospital was provided to the State Long-Term Care Ombudsman and that a written notice was provided to the resident and the resident's responsible party regarding the reason for transfer to the hospital.</p>	F 0623		

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F 0623 SS=D	Continued from page 23 28 Pa. Code 201.14(a) Responsibility of Licensee.	F 0623		
F 0641 SS=D		F 0641		

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F 0641 SS=D	Continued from page 24 483.20(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	<p>1. The Minimum Data Set, MDS, for R61 and R74 have been corrected and re-submitted to Internet Quality Improvement & Evaluation System (IQUIES).</p> <p>2. The Director of Nursing or designee will audit the last Minimum Data Set, MDS, for each resident to determine accuracy of assessment in section J, section O and section N. All issues identified will be corrected per the Resident Assessment Instrument, RAI, manual and resubmitted if warranted.</p> <p>3. The Director of Nursing or designee will re-educate interdisciplinary team on the Resident Assessment Instrument Manual, RAI, guidance for MDS accuracy and coding criteria.</p> <p>4. The Director of Nursing or designee will audit 5% of all newly completed MDS's for accuracy in</p>	Completion Date: 02/20/2025 Status: APPROVED Date: 02/03/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395840	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/09/2025
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F 0641 SS=D	Continued from page 25	F 0641	section J, section O and section N. The audits will be conducted weekly x4 and monthly x2. All findings will be submitted to the Quality Assurance Committee.	

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F 0641 SS=D	Continued from page 26 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 complete accurate Minimum Data Set assessments for two of 31 residents reviewed (Residents 61, 74). Findings include: The Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual, which provides guidance and instructions for the completion of Minimum Data Set (MDS) assessments (mandated assessments of a resident's abilities and care needs), 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 N0300 was to indicate if the resident received any type of injection during the last seven days and Section N0415B Antianxiety Medications was to be coded if the resident took the medication during the seven-day	F 0641		

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F 0641 SS=D	Continued from page 27 look-back period. Physician's orders for Resident 61, dated December 3, 2024, included an order for the resident to receive 0.1 milliliters (mL) Tubersol Solution intradermally (within or between the layers of the skin) for one day. Medication Administration Records (MAR's) for Resident 61, dated December 2024, revealed that staff administered 0.1 mL of Tubersol Solution on December 3, 2024. However, Section N0300 of Resident 61's significant change MDS assessment, dated December 6, 2024, was coded to indicate that the resident did not receive an injection during the seven-day assessment. Interview with the Director of Nursing on January 9, 2025, at 2:08 p.m. confirmed that Section N0300 was coded inaccurately for Resident 61, who received an injection during the seven-day look-back period.	F 0641		

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F 0641 SS=D	Continued from page 28 An annual MDS for Resident 74, dated November 22, 2024, revealed that Section N0415B indicated that the resident did not receive an antianxiety medication in the last seven days. Physician's orders for Resident 74, dated August 16, 2024, included an order for the resident to receive 10 milligrams (mg) of Buspirone (medication used for anxiety) two times a day. Medication Administration Records for Resident 74, dated November, 2024, revealed that the resident received Buspirone during the seven-day look-back period. Interview with the Director of Nursing on January 9, 2025, at 10:35 a.m. confirmed that Section N0415B was coded inaccurately for Resident 74, who received the Buspirone during the seven-day look-back period as ordered. 28 Pa. Code 211.5(f) Clinical Records.	F 0641		

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F 0641 SS=D	Continued from page 29	F 0641		
F 0657 SS=E	483.21(b)(2)(i)-(iii) Care Plan Timing and Revision §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by:	F 0657	1. The plan of care for R46, R54, R65, R73, and R77 will be reviewed and corrected. 2. The Director of Nursing or designee will audit the last comprehensive care plan completed for all current residents. The comprehensive care plan will be updated with all issues identified. 3. The Director of Nursing or designee will re-educate interdisciplinary team on the comprehensive care plan requirements for completion and accuracy in accordance with the Resident Assessment Instrument, RAI, manual and federal regulation. 4. The Director of Nursing or designee will audit all newly completed comprehensive care plans for accuracy. The audits will be conducted weekly x4 and monthly x2. All findings will be submitted to the Quality Assurance Committee.	Completion Date: 02/20/2025 Status: APPROVED Date: 02/03/2025

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F 0657 SS=E	Continued from page 30 Based on review of facility policy and clinical records, as well as staff interviews, it was determined that the facility failed to ensure that a resident's care plan was updated/revised to reflect the resident's specific care needs for five of 31 residents reviewed (Residents 46, 54, 65, 73, 77). Findings include: A facility policy regarding plans of care, dated August 28, 2024, indicated that resident assessments are ongoing and care plans are revised as information about the resident and their condition changes. The interdisciplinary team reviews and updates the care plan when there has been a significant change in the resident's condition; when the desired outcome is not met; when the resident has been readmitted to the facility from a hospital stay; and at least quarterly, in conjunction with the required quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs).	F 0657		

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F 0657 SS=E	<p>Continued from page 31</p> <p>An annual MDS assessment for Resident 46, dated October 17, 2024, revealed that the resident was cognitively intact, was understood and able to understand others, and was dependent with bed mobility, transfers, and lower body dressing. Resident 46's current care plan indicated that she was receiving active range of motion to her bilateral lower extremities.</p> <p>A physical therapy note for Resident 46, dated December 18, 2024, revealed that the resident was referred to physical therapy due to a decline in her lower extremity strength and mobility, as well as to develop an updated restorative nursing program (program developed to maintain or improve the ability to perform activities of daily living).</p> <p>Review of Resident 46's restorative nursing documentation for December 2024 revealed that the resident's active range of motion (the ability to move a joint or muscle using your own strength without any assistance) restorative nursing program to her bilateral lower extremities was stopped on</p>	F 0657		

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F 0657 SS=E	Continued from page 32 December 18, 2024. Interview with the Director of Nursing on January 9, 2025, at 10:39 a.m. confirmed that Resident 46's care plan was not revised to reflect that the active range of motion restorative nursing program to her bilateral lower extremities was stopped on December 18, 2024. An annual MDS assessment for Resident 54, dated December 11, 2024, indicated that the resident was cognitively impaired and had diagnoses that included anxiety (an emotion that can feel like dread or fear in the face of an anticipated threat). An active care plan for Resident 54 indicated that the resident was receiving an anti-anxiety medication. Review of Resident 54's Medication Administration Record (MAR) for January 2025 and review of her current physician's orders revealed that the resident was not ordered to have an anti-anxiety medication. Interview with the Director of Nursing on January 8,	F 0657		

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F 0657 SS=E	Continued from page 33 2025, at 2:19 p.m. confirmed that Resident 54's care plan was not revised to reflect that her anti-anxiety medication had been discontinued. An admission MDS assessment for Resident 65, dated December 1, 2024, indicated that the resident was cognitively intact and had diagnoses that included urinary retention (condition that makes it difficult or impossible to empty the bladder). Physician's orders for Resident 65, dated December 26, 2024, included an order for a catheter to be placed in the resident. Review of Resident 65's care plan indicated that the resident had bladder incontinence (involuntary loss of urine) related to impaired mobility. Interventions included cleaning the resident after any incontinent episodes and toileting the resident everyday after lunch. Interview with the Registered Nurse Assessment Coordinator (RNAC - a nurse who initiates and	F 0657		

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F 0657 SS=E	Continued from page 34 updates the resident's plan of care) on January 8, 2025, at 12:32 p.m. confirmed that Resident 65 had a catheter placed on December 26, 2024; therefore the resident's care plan regarding bladder incontinence no longer applied to the resident and should have been removed, and it was not. A quarterly MDS assessment for Resident 73, dated November 21, 2024, revealed that the resident was understood, could understand others, had diagnoses that included end-stage renal disease (ESRD - a permanent condition that occurs when the kidneys are no longer able to function properly), and received dialysis (a treatment that removes waste products and excess fluid from the blood when the kidneys are no longer functioning properly). A care plan for the resident, dated May 23, 2024, revealed that the resident needed dialysis and staff was to check for bruit and thrill (a bruit is a sound, and a thrill is a vibration that indicate good blood flow in a dialysis fistula or graft) each shift.	F 0657		

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F 0657 SS=E	<p>Continued from page 35</p> <p>Physician's orders for Resident 73, dated December 26, 2024, included an order for staff to monitor the resident's right upper chest med port (an access port placed in individuals receiving hemodialysis to ensure quality treatment and reduce the risk of infection) access area.</p> <p>Review of Resident 73's clinical record revealed that the resident did not have a dialysis access that would require staff to check for a bruit and thrill.</p> <p>Interview with Licensed Practical Nurse 2 on January 8, 2025, at 11:20 a.m. confirmed that Resident 73 only had a med port and no other dialysis access site that would require them to check for a bruit and thrill.</p> <p>However, there was no documented evidence that Resident 73's care plan was updated/revised to reflect individualized, specific care and services interventions to reflect that staff does not need to check a bruit and thrill.</p>	F 0657		

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F 0657 SS=E	Continued from page 36 Interview with the Director of Nursing on January 8, 2025, at 12:56 p.m. confirmed that Resident 73's care plan was not updated/revised to reflect individualized, specific care and services interventions to reflect that staff does not need to check a bruit and thrill. An admission MDS assessment for Resident 77, dated November 25, 2024, revealed that the resident was cognitively impaired, was sometimes understood and able to sometimes understand others, and required assistance with care needs. A care plan for Resident 77, dated December 3, 2024, indicated that the resident was to ambulate with the assist of two and use of a front-wheeled walker and was to transfer with assist of two and use of a front-wheeled walker or utilize grab bar where available. Physician's orders for Resident 77, dated November 21, 2024, included an order for the resident to ambulate with one assist and use of a	F 0657		

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F 0657 SS=E	Continued from page 37 front- wheeled walker. Physician's orders for Resident 77, dated November 21, 2024, included an order for the resident to transfer with one assist and use of a front-wheeled walker or utilize grab bar where available. Interview with the Director of Nursing on January 9, 2025, at 10:39 a.m. confirmed that there was no documented evidence that Resident 77's care plan was revised to reflect her current transfer status. 28 Pa. Code 211.12(d)(5) Nursing Services.	F 0657		
F 0658 SS=D		F 0658		

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F 0658 SS=D	Continued from page 38 483.21(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	<ol style="list-style-type: none"> 1. The physician's orders for R29 and R73 have been corrected. 2. The Director of Nursing or designee will audit current physician orders for hemostats for dialysis residents for accuracy and dialysis residents that are ordered midodrine for clarification. The physician orders will be updated with any issue identified of the affected residents. 3. The Director of Nursing or designee will re-educate all licensed professionals on the facility policy and procedure for providing hemostats for dialysis residents if applicable to care and clarification of physician orders for dialysis residents. 4. The Director of Nursing or designee will audit new dialysis resident physician orders for hemostat use if applicable to care and clarification of physician orders for dialysis residents. The audits will 	Completion Date: 02/20/2025 Status: APPROVED Date: 02/03/2025

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F 0658 SS=D	Continued from page 39	F 0658	be conducted weekly x4 and monthly x2. All findings will be submitted to the Quality Assurance Committee.	

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F 0658 SS=D	Continued from page 40 Based on review of the Pennsylvania Nurse Practice Act and clinical records, as well as staff interviews, it was determined that the facility failed to ensure that physician's orders were clarified when needed for two of 31 residents reviewed (Residents 29, 73). 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. An admission Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 29, dated	F 0658		

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F 0658 SS=D	<p>Continued from page 41</p> <p>December 2, 2024, revealed that the resident was understood, could understand others, had diagnoses that included end-stage renal disease (ESRD - a permanent condition that occurs when the kidneys are no longer able to function properly), and received hemodialysis (a treatment that removes waste products and excess fluid from the blood when the kidneys are no longer functioning properly). A care plan for the resident, dated January 6, 2025, revealed that the resident received dialysis on Monday, Wednesday, and Friday.</p> <p>Physician's orders for Resident 29, dated December 26, 2024, included an order for hemostats (a tool used to control bleeding) to be placed in the resident's room.</p> <p>Interview with Registered Nurse Supervisor 3 on January 8, 2025, at 11:21 a.m. confirmed that Resident 29 has renal disease and receives dialysis three days a week through a fistula (an enlarged vein in the arm that's surgically created to allow for dialysis). She indicated that hemostats could be</p>	F 0658		

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F 0658 SS=D	Continued from page 42 used in an emergency situation if the resident was bleeding from a hemodialysis catheter (a flexible tube inserted into a vein in the neck for dialysis). She further indicated that since the resident has a fistula in her arm and not a hemodialysis catheter in her chest, she would have no use for a hemostat in her room. Registered Nurse Supervisor 3 indicated that the order did not make sense and should have been clarified. Interview with the Director of Nursing on January 8, 2025, at 2:24 p.m. confirmed that there was no need for Resident 29 to have a hemostat in her room and that the order should have been clarified, and it was not. A quarterly MDS assessment for Resident 73, dated November 21, 2024, revealed that the resident was understood, could understand others, had diagnoses that included end-stage renal disease, and received hemodialysis. A care plan for Resident 73, dated May 23, 2024, revealed that the resident receives dialysis on Monday, Wednesday,	F 0658		

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F 0658 SS=D	Continued from page 43 and Friday, and that staff was to provide medications as directed. Physician's orders for Resident 73, dated December 26, 2024, included an order for staff to administer one 10 milligram (mg) tablet of Midodrine (used to treat low blood pressure) every 24 hours as needed for hypotension (low blood pressure). Staff was to administer on Monday, Wednesday, and Friday, and only give on dialysis days as needed. Staff was not to administer the medication if the resident's systolic blood pressure (top number of the blood pressure reading) was greater than 140 millimeters of mercury (mmHg). Review of Resident 73's clinical record revealed no documented evidence that staff was obtaining the resident's blood pressure prior to dialysis on Monday, Wednesday, and Friday to determine if the resident required the one 10 mg tablet of Midodrine. There was no documented evidence in Resident	F 0658		

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F 0658 SS=D	Continued from page 44 73's clinical record to indicate that the physician's order for Midodrine was clarified to be given at the facility or at the dialysis center on dialysis days. Interview with the Director of Nursing on January 8, 2025, at 12:56 p.m. confirmed that there was no documented evidence that staff were obtaining Resident 73's blood pressure on Monday, Wednesday, and Friday to determine if the resident should have been administered the one 10 mg tablet of Midodrine. She indicated that she interpreted the order as a "profile order" and that the Midodrine would not be given at the facility and that it would be given at dialysis if the resident needed it to be administered. She confirmed that the order should have been clarified to determine if the facility or dialysis center should be administering the Midodrine to the resident. Interview with Certified Clinical Hemodialysis Technician-A (CCHTA) 4 on January 8, 2025, at 2:34 p.m. revealed that the facility should be administering the Midodrine to Resident 73 if	F 0658		

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F 0658 SS=D	Continued from page 45 needed prior to arriving at dialysis, because the medication would be in her system due to her dropping her blood pressure at dialysis. Interview with Resident 73's physician on January 8, 2024, at 3:35 p.m. revealed that the order for the Midodrine is an order from dialysis that he ordered because he is the physician at the facility. He indicated that it should be administered at the facility prior to leaving for dialysis. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing Services.	F 0658		
F 0684 SS=E		F 0684		

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F 0684 SS=E	Continued from page 46 483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by:	F 0684	1. The identified concerns for R27 and R77 were immediately corrected. The identified concern for R50 and R69 cannot be corrected. 2. The Director of Nursing or designee will audit current resident's antihypertensive medications for correct administration parameters if indicated in the physician order. The Director of Nursing or designee will audit current treatment administration records (TAR) for wound documentation of completion. The Director or Nursing or designee will audit current residents to ensure current bowel movement documentation accuracy. 3. The Director of Nursing or designee will re-educate all licensed professional nurses on the documentation of administration parameters for antihypertensive medications. The Director of Nursing or designee	Completion Date: 02/20/2025 Status: APPROVED Date: 02/03/2025

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F 0684 SS=E	Continued from page 47	F 0684	<p>will re-educate all licensed professionals on the procedure for completion and documentation of wound care on the treatment administration record (TAR). The Director of Nursing or designee will re-educate all nursing staff on bowel movement documentation and start of bowel protocol if indicated.</p> <p>4. The Director of Nursing or designee will audit 25% per unit of all parameters for antihypertensive medications for accuracy of administration. The Director of Nursing or designee will audit 25% of wound care treatment documentation on the treatment administration record (TAR). The Director of Nursing or designee will audit 10% of each unit for correct initiation of bowel protocol if indicated. The audits will be conducted weekly x4 and monthly x2. All findings will be submitted to the Quality Assurance Committee.</p>	

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F 0684 SS=E	Continued from page 48 Based on review of clinical records, as well as staff interviews, it was determined that the facility failed to provide care and treatment in accordance with professional standards of practice by failing to follow physician's orders for three of 31 residents reviewed (Residents 27, 50, 77), and failed to ensure that bowel protocols were followed as ordered by the physician for one of 31 residents reviewed (Resident 69). Findings include: A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 27, dated December 2, 2024, revealed that the resident was understood and could understand others, and had a diagnosis which included hypertension (high blood pressure). A care plan for the resident, dated August 8, 2024, revealed that the resident had an altered cardiovascular (relating to the heart and blood vessels) status related to hypertension and that staff	F 0684		

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F 0684 SS=E	Continued from page 49 were to administer the resident's medications per orders. Physician's orders for Resident 27, dated April 22, 2024, included an order for the resident to receive one 10 milligram (mg) tablet of Hydralazine (used to treat high blood pressure) three times a day. Staff was to hold the medication if the resident's systolic blood pressure (the top number of a blood pressure) was less than 100 millimeters of mercury (mmHg) or if the resident's heart rate was less than 60 beats per minute. Review of Resident 27's clinical record, including the resident's Medication Administration Record (MARs), dated November and December 2024, and January 2025, revealed no documented evidence that staff was obtaining the resident's blood pressure and heart rate prior to the administration of the one 10 mg tablet of Hydralazine three times a day. Interview with the Director of Nursing on January 8,	F 0684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395840	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/09/2025	
NAME OF PROVIDER OR SUPPLIER: PATRIOT VILLAGE STATE LICENSE NUMBER: 167902		STREET ADDRESS, CITY, STATE, ZIP CODE: 495 WEST PATRIOT STREET SOMERSET, PA 15501		
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F 0684 SS=E	Continued from page 50 2025, at 10:43 a.m. confirmed that there was no documented evidence that staff was obtaining Resident 27's blood pressure and heart rate prior to the administration of the one 10 mg tablet of Hydralazine three times a day. An admission MDS assessment for Resident 50, dated December 9, 2024, revealed that the resident had mild cognitive impairment, was understood and able to understand others, had pain, was administered routine and as needed pain medications, required substantial assist with bed mobility, was dependent for transfers, was not ambulatory, was frequently incontinent of bowel, had two Stage 2 pressure ulcers (pressure wound with skin loss) present on admission, had a surgical wound and wound infection, had a pressure-relieving device to bed and chair, and received pressure ulcer care and surgical wound care. A care plan for Resident 50, dated December 3, 2024, revealed that the resident had actual skin impairment and that staff was to administer treatments as directed.	F 0684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395840	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/09/2025	
NAME OF PROVIDER OR SUPPLIER: PATRIOT VILLAGE STATE LICENSE NUMBER: 167902		STREET ADDRESS, CITY, STATE, ZIP CODE: 495 WEST PATRIOT STREET SOMERSET, PA 15501		
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F 0684 SS=E	Continued from page 51 Physician's orders for Resident 50, dated January 3, 2025, included an order for the resident to receive 10 milligrams (mg) of Oxycodone HCL (a narcotic drug used to treat moderate to severe pain) every four hours as needed for moderate to severe pain. Review of Resident 50's MAR for January 2025 revealed that 10 mg of Oxycodone HCL was administered to the resident on January 4, 2025, at 12:11 a.m. and 1:11 p.m.; January 5, 2025, at 2:52 p.m., 6:56 p.m. and 11:15 p.m.; and January 6, 2025, at 5:09 a.m. However, a review of the resident's controlled medication record (a form that accounts for each tablet/pill/dose of a controlled drug), dated January 2025, revealed that 10 mg of Oxycodone HCL was not signed out for administration on the above-mentioned dates and times. Interview with the Director of Nursing on January 9, 2025, at 2:07 p.m. confirmed that 10 mg of Oxycodone HCL was not signed out on Resident	F 0684		

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F 0684 SS=E	Continued from page 52 50's controlled medication record as being administered on the above-mentioned dates and times. Physician's orders for Resident 50, dated December 3, 2024, included an order to apply betadine (a solution used to treat and prevent infection) to the intergluteal cleft and buttocks flap closure with sutures and cover with comfort foam twice daily. A review of the resident's Treatment Administration Record (TAR), dated December 2024, revealed that the resident did not receive the treatment as ordered on December 4, 8, 10 and 21, 2024, on the day shift. Interview with the Nursing Home Administrator on January 9, 2025, at 10:39 a.m. confirmed that there was no documented evidence that the treatment to Resident 50's interguteal cleft and buttocks flap closer was administered to the resident on the above-mentioned dates and shifts. An admission MDS assessment for Resident 77,	F 0684		

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F 0684 SS=E	<p>Continued from page 53</p> <p>dated November 25, 2024, revealed that the resident was cognitively impaired, was sometimes understood and able to sometimes understand others, required assistance with care needs, and had a diagnosis of hypertension (high blood pressure).</p> <p>A physician's order for Resident 77, dated November 27, 2024, included an order for the resident to receive 25 mg of Lopressor (a medication used to treat hypertension) twice daily with instructions to hold the medication if the resident's heart rate was less than 60 beats per minute.</p> <p>Review of the Resident 77's MAR for November and December 2024, as well as review of the resident's clinical record, revealed no documented evidence that the resident's heart rate was obtained prior to administering the Lopressor.</p> <p>Interview with the Director of Nursing on January 8, 2025, at 1:35 p.m. confirmed that there was no documented evidence that Resident 77's heart rate</p>	F 0684		

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F 0684 SS=E	Continued from page 54 was obtained prior to administering the Lopressor. A quarterly MDS assessment for Resident 69, dated November 20 , 2024, revealed that the resident was cognitively intact and was always incontinent of bowel movements. Physician's orders for Resident 69, dated September 16, 2024, included orders for the resident to receive 30 milliliters (mL) of Milk of Magnesia (MOM) as needed for constipation if no bowel movement by day three, a 10 mg bisacodyl suppository rectally as needed if no bowel movement for three days after MOM, and Fleets enema to be given rectally as needed if no bowel movement for four days. The resident's care plan, dated October 31, 2024, indicated that the resident had constipation and mediations were to be administered as directed. Review of Resident 69's bowel records for November and December 2024 revealed that there was no documented evidence that the resident had a bowel movement from November 2 through 8 and December 26 through 30, 2024.	F 0684		

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F 0684 SS=E	Continued from page 55 Review of the November and December 2024 MAR's for Resident 69 revealed that staff did not initiate or follow the bowel protocol as ordered by the physician. Interview with the Director of Nursing on January 9, 2025, at 11:31 a.m. confirmed that the physician's orders for bowel medications were not followed for Resident 69. 28 Pa. Code 211.12(d)(1)(5) Nursing Services.	F 0684		
F 0686 SS=D		F 0686		

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F 0686 SS=D	Continued from page 56 483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by:	F 0686	1. The medical record for R19 and R50 cannot be corrected. 2. The Director of Nursing or designee will audit current treatment administration record (TAR) for wounds and mattress orders on current residents for completion and accuracy. 3. The Director of Nursing or designee will re-educate all licensed professionals on the procedure for completion and documentation of wound care on the treatment administration record (TAR) and mattress orders. 4. The Director of Nursing or designee will audit 25% of wound care treatment documentation on the treatment administration record (TAR) and mattress orders. The audits will be conducted weekly x4 and monthly x2. All findings will be submitted to the Quality Assurance Committee.	Completion Date: 02/20/2025 Status: APPROVED Date: 02/03/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395840	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/09/2025	
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F 0686 SS=D	Continued from page 57 Based on review of clinical records, as well as staff interviews, it was determined that the facility failed to ensure that treatments and preventative measures for pressure ulcers were provided as ordered by the physician for two of 31 residents reviewed (Residents 19, 50). Findings include: An admission MDS assessment for Resident 19, dated December 6, 2024, revealed that the resident had mild cognitive impairment, was understood and able to understand others, had impaired mobility with deconditioning, had one pressure area, two unstageable and three Stage 3 pressure ulcers (pressure wound with skin loss) upon admission, and received pressure ulcer care. A care plan for Resident 19, dated December 8, 2024, revealed that staff was to administer treatments as ordered. Physician's orders for Resident 19, dated December 8, 2024, included an order to apply skin prep	F 0686		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395840	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/09/2025	
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F 0686 SS=D	Continued from page 58 (protectant) to the purple area on the left lateral heel and cover with comfort foam (an absorbent dressing). Physician's orders, dated December 10, 2024, included an order to cleanse the right buttocks with wound cleaner, apply silver alginate (topical medication to decrease microbes) to the base of the wound and cover with a bordered foam dressing (maintains a moist environment), apply skin prep to the right hallux (enlarged joint on the base of the big toe) and let open to air, and lastly to cleanse the right heel with wound cleanser, apply silver alginate, and cover with a bordered foam dressing. Physician's orders, dated December 11, 2024, included an order to cleanse the left inner ankle with wound cleaner, pat dry and apply Xeroform (a non adhering mesh petroleum based dressing), and cover with comfort foam. Physician's orders, dated December 25, 2024, included an order to cleanse the left hallux with wound cleaner, apply skin prep, and let open to air. A review of the resident's Treatment Administration Record (TAR), dated January 2025, revealed that the resident did not receive the above treatments as ordered on January	F 0686		

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F 0686 SS=D	Continued from page 59 4, 2025, on the day shift. Interview with Registered Nurse Supervisor 5 on January 9, 2025, at 12:45 p.m. confirmed that there was no documented evidence that the treatments to Resident 19's right and left lateral heel, right buttocks, right and left hallux, and left inner ankle were administered to the resident as ordered on January 4, 2025, on the day shift. In addition, there is no documented evidence in the clinical record that the resident refused wound care. Interview with the Director of Nursing on January 9, 2025, at 12:58 p.m. confirmed that there was no documented evidence that the treatments to Resident 19 were administered on the above-mentioned date and shift. An admission MDS assessment for Resident 50, dated December 9, 2024, revealed that the resident had mild cognitive impairment, was understood and able to understand others, required substantial assist with bed mobility, was dependent for transfers, was	F 0686		

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F 0686 SS=D	Continued from page 60 not ambulatory, was frequently incontinent of bowel, had two Stage 2 pressure ulcers on admission, had a surgical wound, wound infection, had a pressure-relieving device to bed and chair, and received pressure ulcer care and surgical wound care. A care plan for Resident 50, dated December 3, 2024, revealed that the resident had a bariatric air mattress, and that staff was to administer treatments as directed. Physician's orders for Resident 50, dated December 3, 2024, included an order for a bariatric air mattress. Observations on January 8, 2025, at 11:04 a.m. revealed that Resident 50 did not have a bariatric air mattress on her bed. Interview with the Director of Nursing on January 8, 2025, at 2:24 p.m. confirmed that Resident 50 did not have a bariatric air mattress on her bed. She indicated that the resident had a bariatric air mattress when she was on the first floor. She indicated that Resident 50 had just moved to the third floor a few days ago and the staff did not move	F 0686		

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F 0686 SS=D	Continued from page 61 the air mattress with her. Physician's orders for Resident 50, dated December 3, 2024, included an order to cleanse the right and left buttocks with warm soap and water, pat dry, apply zinc oxide (topical medication to treat skin irritations), and cover with comfort foam twice daily. A review of the resident's Treatment Administration Record, dated December 2024, revealed that the resident did not receive the treatment as ordered on December 8 and December 21, 2024, on the day shift. Interview with the Nursing Home Administrator on January 9, 2025, at 10:39 a.m. confirmed that there was no documented evidence that the treatment to Resident 50's left and right buttocks was administered to the resident on the above-mentioned dates and shifts. 28 Pa. Code 211.12(d)(1)(5) Nursing Services.	F 0686		
F 0688 SS=D		F 0688		

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F 0688 SS=D	Continued from page 62 483.25(c)(1)-(3) Increase/Prevent Decrease in ROM/Mobility §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by:	F 0688	1. The medical record for R10 cannot be corrected. 2. The Director of Nursing or designee will audit current residents ordered passive range of motion (PROM) for documentation of completion. 3. The Director of Nursing or designee will re-educate nursing staff on the procedure for completion and documentation of passive range of motion (PROM) for the restorative nursing program (RNP). 4. The Director of Nursing or designee will audit 25% of passive range of motion (PROM) for completion and documentation of the restorative nursing program (RNP). The audits will be conducted weekly x4 and monthly x2. All findings will be submitted to the Quality Assurance Committee.	Completion Date: 02/20/2025 Status: APPROVED Date: 02/03/2025

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F 0688 SS=D	Continued from page 63 Based on a review of clinical records, as well as resident and staff interviews, it was determined that the facility failed to ensure that restorative nursing programs to maintain or improve physical abilities were provided as ordered and/or care planned for one of 31 residents reviewed (Resident 10). Findings include: A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 10, dated December 19, 2024, revealed that the resident was cognitively impaired, was usually understood and usually able to understand others, had functional limitation in range of motion (ROM - extend or limit to which a joint can be moved) to his bilateral upper and lower extremities, was dependent with care needs, and had diagnoses that included muscle contractures (a permanent shortening and tightening of muscle fibers that reduces flexibility and makes movement difficult) of multiple sites, contracture to right hand,	F 0688		

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F 0688 SS=D	Continued from page 64 and a personal history of traumatic brain injury. A care plan for Resident 10 addressing his decreased ROM and contractures, dated February 10, 2017, included an intervention, revised October 9, 2024, for a restorative nursing program to provide passive range of motion (PROM - movement of a joint through the range of motion with no effort from the patient) to his bilateral lower extremities involving hip/knee flexion and extension and hip abduction (movement of legs away from the center of the body) and adduction (movement of legs toward the center of the body) at least daily. Review of Resident 10's restorative nursing documentation from September 2024 through January 2025, as well as review of nursing notes, revealed that there was no documented evidence that the restorative nursing program to provide PROM to his bilateral lower extremities involving hip/knee flexion and extension and hip abduction and adduction was completed at least daily as per the resident's plan of care on the following dates: September 2, 3, and 13, 2024; October 2, 11, 14,	F 0688		

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NAME OF PROVIDER OR SUPPLIER: PATRIOT VILLAGE STATE LICENSE NUMBER: 167902		STREET ADDRESS, CITY, STATE, ZIP CODE: 495 WEST PATRIOT STREET SOMERSET, PA 15501		
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F 0688 SS=D	Continued from page 65 15, 16, 19, 24, 25, 29, 30, and 31, 2024; November 2, 3, 11, 21, 23, 26, 27, and 28, 2024; December 1, 6, 9, 11, 14, 20, 22, 23, 25, and 30, 2024; and January 2, 3, 6, 7, and 8, 2025. An interview with the Director of Nursing on January 9, 2025, at 2:07 p.m. confirmed that there was no documented evidence that Resident 10's restorative nursing program to provide PROM to his bilateral lower extremities involving hip/knee flexion and extension and hip abduction and adduction was completed on the above-mentioned dates. 28 Pa. Code 211.12(d)(3)(5) Nursing Services.	F 0688		
F 0690 SS=D		F 0690		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395840	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/09/2025
NAME OF PROVIDER OR SUPPLIER: PATRIOT VILLAGE STATE LICENSE NUMBER: 167902		STREET ADDRESS, CITY, STATE, ZIP CODE: 495 WEST PATRIOT STREET SOMERSET, PA 15501		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0690 SS=D	Continued from page 66 483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2) For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.	F 0690	1. The medical record for R34 cannot be corrected. 2. The Director of Nursing or designee will audit current residents ordered urinary catheters for positioning below the level of the bladder and tubing off the floor. 3. The Director of Nursing or designee will re-educate nursing staff on the procedure positioning of urinary catheters below the level of the bladder and tubing off the floor. 4. The Director of Nursing or designee will audit 25% of residents with urinary catheters for proper positioning of the urinary catheter and placement of the tubing. The audits will be conducted weekly x4 and monthly x2. All findings will be submitted to the Quality Assurance Committee.	Completion Date: 02/20/2025 Status: APPROVED Date: 02/03/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395840	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/09/2025
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NAME OF PROVIDER OR SUPPLIER: PATRIOT VILLAGE STATE LICENSE NUMBER: 167902	STREET ADDRESS, CITY, STATE, ZIP CODE: 495 WEST PATRIOT STREET SOMERSET, PA 15501
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F 0690 SS=D	Continued from page 67 This REQUIREMENT is not met as evidenced by:	F 0690		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395840	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/09/2025
NAME OF PROVIDER OR SUPPLIER: PATRIOT VILLAGE STATE LICENSE NUMBER: 167902		STREET ADDRESS, CITY, STATE, ZIP CODE: 495 WEST PATRIOT STREET SOMERSET, PA 15501		
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F 0690 SS=D	Continued from page 68 Based on review of clinical records, as well as observations and staff interviews, it was determined that the facility failed to ensure that residents received proper care for indwelling urinary catheters for one of 31 residents reviewed (Resident 34). Findings include: A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 34, dated December 19, 2024, indicated that the resident was understood and able to understand others, and had an indwelling urinary catheter (a flexible catheter used to drain urine from the bladder into a drainage collection bag). A care plan for the resident, dated April 29, 2024, revealed that the resident had an indwelling urinary catheter and staff was to position the indwelling urinary catheter bag and tubing below the level of the bladder. Observations of Resident 34 on January 7, 2025, at	F 0690		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395840	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/09/2025
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0690 SS=D	Continued from page 69 10:41 a.m. and 11:33 a.m. revealed that the resident was lying in bed with his indwelling urinary catheter drainage bag and tubing lying on the floor. Interview with Licensed Practical Nurse 1 on January 7, 2025, at 11:34 a.m. confirmed that Resident 34's indwelling urinary catheter drainage bag and tubing should not be on the floor. Interview with the Director of Nursing on January 7, 2025, at 2:40 p.m. confirmed that Resident 34's indwelling catheter tubing and drainage bag should not be on the floor. 28 Pa. Code 211.12(d)(3)(5) Nursing Services.	F 0690		
F 0695 SS=D		F 0695		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395840	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/09/2025
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F 0695 SS=D	Continued from page 70 483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by:	F 0695	<ol style="list-style-type: none"> The physician order for R29 was immediately corrected. The Director of Nursing or designee will audit current physician oxygen orders to ensure oxygen is administered in accordance with the physician order. The Director of Nursing or designee will re-educate nursing staff on the procedure that oxygen is administered in accordance with the physician order and documented on the medication administration record. The Director of Nursing or designee will audit 25% of residents with oxygen physician orders and that the correct oxygen rate is administered. The audits will be conducted weekly x4 and monthly x2. All findings will be submitted to the Quality Assurance Committee. 	Completion Date: 02/20/2025 Status: APPROVED Date: 02/03/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395840	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/09/2025	
NAME OF PROVIDER OR SUPPLIER: PATRIOT VILLAGE STATE LICENSE NUMBER: 167902	STREET ADDRESS, CITY, STATE, ZIP CODE: 495 WEST PATRIOT STREET SOMERSET, PA 15501			
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F 0695 SS=D	Continued from page 71 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 residents received oxygen as ordered by the physician for one of 31 residents reviewed (Resident 29). Findings include: The facility's policy regarding oxygen therapy, dated August 28, 2024, indicated that oxygen was to be administered in accordance with physician's orders. A admission Minimum data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 29, dated December 2, 2024, revealed that the resident was cognitively intact and had diagnoses that included congestive obstructive pulmonary disease (a lung disease causing restricted airflow and breathing problems) and heart failure (a condition in which the heart does not pump blood as well as it should). Resident 29's	F 0695		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395840	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/09/2025
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F 0695 SS=D	Continued from page 72 care plan, dated January 6, 2025, indicated that she had difficulty breathing related to chronic respiratory failure. Physician's orders for Resident 29, dated January 1, 2025, included an order for the resident to receive continuous oxygen at a flow rate of 3 liters per minute via nasal cannula (tubes that deliver oxygen into the nostrils). Observations of Resident 29 on January 7, 2025, at 12:04 p.m. and 3:01 p.m. and January 8, 2025, at 12:45 p.m. and 1:58 p.m. revealed that the resident was in her room receiving oxygen from an oxygen concentrator (electrical machine that concentrates oxygen from the air) that was set at 3.5 liters per minute. Interview with Licensed Practical Nurse 6 on January 8, 2025, at 2:05 p.m. confirmed that Resident 29's oxygen flow rate was set at 3.5 liters per minute and not 3.0 liters per minute as ordered by the physician. Licensed Practical Nurse 6	F 0695		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395840	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/09/2025	
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F 0695 SS=D	<p>Continued from page 73</p> <p>indicated that she felt the oxygen was set at 3 and that possibly the resident adjusted the rate of the oxygen. The licensed practical nurse questioned Resident 29 if she ever adjusts the oxygen herself and she said that she can. Resident 29's care plan, dated January 6, 2025, did not indicate that the resident adjusts the oxygen flow rate.</p> <p>Interview with Registered Nurse Supervisor 3 on January 8, 2025, at 2:10 p.m. confirmed that Resident 29's oxygen flow rate was set at 3.5 liters per minute and not 3.0 liters per minute as ordered by the physician, and that there was no documentation in the resident's care plan or nursing notes that indicated that the resident adjusts her own oxygen rate.</p> <p>Interview with the Director of Nursing on January 8, 2025, at 2:24 p.m. confirmed that Resident 29's oxygen flow rate should be set at 3 liters per minute continuously as per physician order, and it was not.</p> <p>28 Pa. Code 211.12(d)(1)(3)(5) Nursing Services.</p>	F 0695		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395840	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/09/2025
NAME OF PROVIDER OR SUPPLIER: PATRIOT VILLAGE STATE LICENSE NUMBER: 167902		STREET ADDRESS, CITY, STATE, ZIP CODE: 495 WEST PATRIOT STREET SOMERSET, PA 15501		
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F 0755 SS=D	<p>483.45(a)(b)(1)-(3) Pharmacy Srvcs/Procedures/Pharmacist/Records</p> <p>§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.</p> <p>§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.</p> <p>§483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-</p> <p>§483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility.</p> <p>§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</p> <p>§483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>This REQUIREMENT is not met as evidenced by:</p>	F 0755	<ol style="list-style-type: none"> The medication administration record for R50 cannot be corrected. The Director of Nursing or designee will audit current resident's controlled substance accountability records for accuracy of administration times in comparison to the medication administration record (MAR). The Director of Nursing or designee will re-educate all licensed professional nurses on the facility policy and procedure for administration of controlled substances. The Director of Nursing or designee will audit 25% per unit of all administered controlled substances for accurate documentation at the time of administration. The audits will be conducted weekly x4 and monthly x2. All findings will be submitted to the Quality Assurance Committee. 	<p>Completion Date: 02/20/2025 Status: APPROVED Date: 02/03/2025</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395840	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/09/2025
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F 0755 SS=D	Continued from page 75	F 0755		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395840	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/09/2025	
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F 0755 SS=D	Continued from page 76 Based on review of 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 one of 31 residents reviewed (Resident 50). Findings include: The facility's policy regarding documentation of medication administration, dated August 28, 2024, indicated that the nurse was to document all medications administered to each resident on the resident's medication administration record (MAR). An admission Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 50, dated December 9, 2024, revealed that the resident had mild cognitive impairment, was understood and able to understand others, had pain, and was administered routine and as needed pain medications.	F 0755		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395840	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/09/2025	
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F 0755 SS=D	<p>Continued from page 77</p> <p>Physician's orders for Resident 50, dated December 3, 2024, included an order for the resident to receive 5 milligrams (mg) of Oxycodone HCL (a narcotic drug used to treat moderate to severe pain) every four hours as needed for moderate to severe pain on a pain scale of 4 to 10.</p> <p>The controlled drug record for Resident 50 for December 2024 indicated that one dose of Oxycodone HCL was signed-out for administration to the resident on December 8, 2024, at 10:10 p.m. and December 27, 2024, at 10:21 p.m. However, the resident's clinical record, including the Medication Administration Records (MAR's) and nursing notes, contained no documented evidence that the signed-out doses of Oxycodone HCL were actually administered to the resident on these dates and times.</p> <p>Interview with the Director of Nursing on January 9, 2025, at 2:07 p.m. confirmed that there was no documented evidence that staff administered the</p>	F 0755		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395840	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/09/2025
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F 0755 SS=D	Continued from page 78 signed-out doses of Oxycodone HCL to Resident 50 on the above dates and times. 28 Pa. Code 211.9(h) Pharmacy Services. 28 Pa. Code 211.12(d)(1)(5) Nursing Services.	F 0755		
F 0759 SS=D		F 0759		

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F 0759 SS=D	Continued from page 79 483.45(f)(1) Free of Medication Error Rts 5 Prcnt or More §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by:	F 0759	1. The medication administration for R54 cannot be corrected. The parameters for antihypertensive medication for R54 was immediately corrected. 2. The Director of Nursing or designee will audit current resident's insulin medication administration record (MAR) for accuracy of timing of insulin administration and antihypertensive medications for correct administration parameters if indicated in the physician order. 3. The Director of Nursing or designee will re-educate all licensed professional nurses on the facility policy and procedure for timing of administration of insulin and administration parameters for antihypertensive medications. 4. The Director of Nursing or designee will audit 25% per unit of	Completion Date: 02/20/2025 Status: APPROVED Date: 02/03/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395840	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/09/2025
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F 0759 SS=D	Continued from page 80	F 0759	all timing of insulin administration and parameters for antihypertensive medications. The audits will be conducted weekly x4 and monthly x2. All findings will be submitted to the Quality Assurance Committee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395840	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/09/2025
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F 0759 SS=D	Continued from page 81 Based on review of manufacturer's instructions and clinical records, as well as observations and staff interviews, it was determined that the facility failed to maintain a medication administration error rate of less than five percent. Findings include: Observations during medication administration on January 8, 2025, at 8:19 a.m. and at 11:51 a.m. revealed that two medication administration errors were made during 36 opportunities for error, resulting in a medication administration error rate of 6.25 percent. Physician's orders for Resident 27, dated April 22, 2024, included an order for the resident to receive one 10 milligram (mg) tablet of Hydralazine (used to treat high blood pressure) three times a day. Staff was to hold the medication if the resident's systolic blood pressure (the top number of a blood pressure) was less than 100 millimeters of mercury	F 0759		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395840	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/09/2025	
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F 0759 SS=D	Continued from page 82 (mmHg) or if the resident's heart rate was less than 60 beats per minute. Observations during the medication administration on January 8, 2025, at 8:19 a.m. revealed that Licensed Practical Nurse 7 prepared and administered Resident 27 her one 10 mg tablet of Hydralazine. However, Licensed Practical Nurse 7 did not obtain the resident's blood pressure and pulse prior to the administration of the one 10 mg tablet of Hydralazine. There was no documented evidence in the resident's clinical record including the Medication Administration Record (MAR) that the resident's blood pressure and pulse were taken prior to the administration of the one 10 mg tablet of Hydralazine on January 8, 2025, at 8:19 a.m. Interview with Licensed Practical Nurse 7 on January 8, 2025, at 9:30 a.m. confirmed that she did not obtain a blood pressure or pulse on Resident 27 prior to the administration of the resident's 10 mg tablet of Hydralazine. She indicated that it did not "pop up" for her to obtain the resident's blood	F 0759		

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F 0759 SS=D	Continued from page 83 pressure and pulse prior to the administration. The manufacturer's instructions for Lispro (a fast-acting insulin), dated July 2023, indicated that the Lispro should be provided 15 minutes before or immediately after a meal. Physician's orders for Resident 54, dated October 1, 2024, included an order for her to be provided Lispro Insulin subcutaneously before meals as per a sliding scale (a set of instructions for administering insulin dosages based on specific blood glucose readings): if blood sugar was 150-200 = 3 units, 201-250 = 6 units, 251-300 = 9 units, 301-350 = 12 units, and if greater than 351 staff was to and call the physician. Observations during medication administration on January 8, 2025, at 11:42 a.m. revealed that Licensed Practical Nurse 2 obtained a blood glucose sample for Resident 54 with a reading of 202, indicating that the resident should receive six units of Lispro Insulin. At 11:51 a.m. Licensed	F 0759		

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F 0759 SS=D	Continued from page 84 Practical Nurse 2 then administered the resident six units of Lispro Insulin. At 11:53 a.m. the resident was taken from her room and taken to the main dining room. At 12:32 p.m. the resident was provided her lunch meal tray, which was approximately forty-one minutes after receiving her Lispro Insulin. Interview with the Director of Nursing on January 8, 2025, at 1:38 p.m. confirmed that the nurse should have waited to give Resident 54's Lispro Insulin per the manufacturer's instructions. 28 Pa. Code 211.12(d)(1)(5) Nursing Services.	F 0759		
F 0761 SS=D		F 0761		

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F 0761 SS=D	Continued from page 85 483.45(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	1. The identified concern for the eye drop solution and intravenous, IV, fluids was immediately corrected. The identified concern R37and R69 cannot be corrected. 2. The Director of Nursing or designee will audit all current medication rooms for outdated IV fluids and all medication carts for proper labeling and storage of eye drops. The Director of Nursing or designee will audit residents controlled opioid medication cards for accuracy of administration from the correct card. 3. The Director of Nursing or designee will re-educate all licensed professional nurses on the facility policy and procedure for disposing of expired medications, labeling of open containers in medication cart, which includes monthly audits and opioid medication administrations to be given from the correct medication card.	Completion Date: 02/20/2025 Status: APPROVED Date: 02/03/2025

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F 0761 SS=D	Continued from page 86	F 0761	4. The Director of Nursing or designee will audit 25% per unit of disposal of expired medications, labeling of open containers in medication carts and opioid administrations from the correct medication card. The audits will be conducted weekly x4 and monthly x2. All findings will be submitted to the Quality Assurance Committee.	

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F 0761 SS=D	Continued from page 87 Based on review of facility policies, as well as observations and staff interviews, it was determined that the facility failed to properly date medications after they were opened in one of three medication carts reviewed (First floor cart), failed to discard expired medical supplies, and failed to sign out routine narcotics on the appropriate narcotic medication card (Residents 37, 69). Findings include: The facility's policy regarding medication storage and disposal, dated August 28, 2024, revealed that the facility would properly date medication vials after they were opened and remove outdated supplies from the facility inventory. Observations in the First floor medication cart on January 7, 2025, at 11:01 a.m. revealed that there was one 10 ml (milliliter) bottle of Systane (medication used to relieve dry, irritated eyes) eye drops opened and undated.	F 0761		

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F 0761 SS=D	Continued from page 88 Interview with Licensed Practical Nurse 6 on January 7, 2025, at 11:10 p.m. confirmed that the Systane eye drops were open and should have been labeled with the date it was opened. Observations in the First floor medication room on January 7, 2025, at 11:15 a.m. revealed that there were a total of 12 intravenous (IV) fluid bags in the cupboard in circulation that were expired. The expired IV fluids included seven 50 cc bags of normal saline solution (NSS) that expired in October 2024, two 1000 cc bags of 5 percent dextrose (sugar) and 0.45 percent NSS with 20 MEQ (milliequivalents) potassium that expired in October 2024, two 1000 cc bags of NSS with 5 percent dextrose that expired December 2024, one 1000 cc bag of 5 percent dextrose and 0.2 percent NSS that expired in December 2024. Interview with Licensed Practical Nurse 6 on January 7, 2025, at 11:25 a.m. confirmed that the 12 IV bags were expired and should have been	F 0761		

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F 0761 SS=D	<p>Continued from page 89</p> <p>discarded. She also commented that she thought the overnight staff checked for outdated supplies.</p> <p>Interview with the Nursing Home Administrator on January 7, 2025, at 3:20 p.m. confirmed that the opened vial of Systane eye drops should have been dated upon opening and the IV bags were expired and should have been discarded.</p> <p>A significant change Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 37, dated November 15, 2024, revealed that the resident was cognitively intact, had frequent pain, received routine and as needed pain medications, and received an opioid (narcotic pain reliever).</p> <p>Physician's orders, dated October 14, 2024, included an order for the resident to receive 50 milligrams (mg) of Tramadol (a narcotic pain medication) every six hours as needed for moderate to severe pain and physician's orders, dated December 11, 2024, included an order for the</p>	F 0761		

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F 0761 SS=D	Continued from page 90 resident to receive 50 milligrams (mg) of Tramadol twice a day for pain. Resident 37's controlled drug accountability records for December 2024 revealed that staff signed out routine doses of Tramadol out of the "as needed" Tramadol medication card at 7:30 a.m. and/or 7:30 p.m. on December 11-16, 2024. A quarterly MDS assessment for Resident 69, dated November 20, 2024, revealed that the resident was cognitively intact, had frequent pain, received routine and as needed pain medications, and received an opioid. Physician's orders, dated November 3, 2024, included an order for the resident to receive 50 mg of Tramadol every six hours as needed for moderate to severe pain, and physician's orders, dated December 11, 2024, included an order for the resident to receive 50 milligrams (mg) of Tramadol twice a day for pain.	F 0761		

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F 0761 SS=D	Continued from page 91 Resident 69's controlled drug accountability records for December 2024 revealed that staff signed out routine doses of Tramadol out of the "as needed" Tramadol medication card at 7:30 p.m. on December 11-19 and 21-27, 2024. Interview with the Nursing Home Administrator on January 7, 2024, at 3:20 p.m. confirmed that the opened vial of Systane eye drops should have been dated upon opening and the IV bags were expired and should have been discarded, and confirmed that Residents 37 and 69 should not have had their routine narcotics signed out of the "as needed" narcotic medication card. 28 Pa. Code 211.9(a)(1) Pharmacy Services.	F 0761		
F 0804 SS=E		F 0804		

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F 0804 SS=E	Continued from page 92 483.60(d)(1)(2) Nutritive Value/Appear, Palatable/Prefer Temp §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by:	F 0804	1. The identified concern for R45 was immediately corrected. 2. Dietary manager and registered dietician will continue to monitor by completing monthly food committee meetings as well as completing random test tray audits. 3. Staff will be in-serviced on the importance of serving food and drinks that are palatable, attractive, and at safe and appetizing temperatures. Nursing staff will also be educated on serving meal trays promptly when trays are received on the unit to maintain adequate temperature of food. 4. Dietary manager and registered dietician will complete test trays daily for 2 weeks. Followed by 4 trays a week for 2 weeks. Then weekly times two months. All findings will be submitted to the Quality Assurance Committee.	Completion Date: 02/20/2025 Status: APPROVED Date: 02/03/2025

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F 0804 SS=E	Continued from page 93 Based on resident and staff interviews, and a meal test tray, it was determined that the facility failed to serve food items that were palatable to the residents. Findings include: Interview with Resident 73 on January 7, 2025, at 10:47 a.m. revealed that when she receives her meal tray, the food is not as warm as she likes it to be, and the taste of the food has a lot to be desired. Interview with Resident 74 on January 7, 2025, at 10:33 a.m. revealed that the food is cold. Interview with Resident 77 on January 7, 2025, at 11:12 a.m. revealed that the food is terrible and she only drinks milk. Interview with a group of residents on January 8, 2025, at 10:07 a.m. revealed that food is an ongoing issue. The food is cold, food is dry, and they always have pork and chicken. Interview with Resident 45 on January 8, 2025, at 12:07 p.m., while she was eating sweet and sour pork for lunch, revealed that she could not taste the sweet and sour.	F 0804		

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F 0804 SS=E	Continued from page 94 Observations in the kitchen of the tray line for the East Side Third floor cart on January 8, 2025, at 11:38 a.m. and First cart for East Side Third floor was completed at 11:40 a.m. A separate, open, non-insulated cart was used for overflow trays for the rest of East side. Staff indicated that there was not enough room to put all of the trays on the insulated, enclosed cart. Juices and milk were kept on top of the enclosed cart in a bin of ice. The meal for lunch included scalloped chicken with mushrooms, alternate of sweet and sour pork, buttered potatoes, mixed vegetable blend, and chocolate pudding. The last tray was placed on the open cart and left the kitchen at 11:45 a.m., arrived on East Side Third floor at 11:46 a.m.. The first tray was out at 11:47 a.m. and at 11:51 a.m. last tray was removed from the cart. The test tray was removed from the open cart at 11:51 a.m. The food items were not palatable to taste or temperature. Both the chicken and the pork were tested. The scalloped chicken with mushrooms was 140 degrees Fahrenheit (F). The	F 0804		

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F 0804 SS=E	Continued from page 95 texture was soft, but the taste was bland. The mushroom gravy on top of the chicken had no taste and there were no visible mushrooms. The alternate of sweet and sour pork was 122 degrees F, the texture was soft and shredded, but was cool and the taste was bland. There were no visible pineapple chunks and no taste of sweet and sour. Interview with the food service director and the Dietician at the time of the test tray indicated that because of cardiac diets, they do not put salt in the food, and the residents are given salt packets on their trays. Interview with Cook 8 and the Food Service Director on January 8, 2025, at 3:18 p.m. indicated that they follow the recipes. The Food Service Director indicated that the green peppers and onions in the pork recipe cook down a bit when cooking them. There were no visible green peppers or onions noted to the pork when tasting it. Also, she indicated that they use only pineapple juice when preparing the pork and do not use the pineapple chunks called for in the recipe. The recipe for the pork also called for brown sugar, vinegar and soy	F 0804		

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F 0804 SS=E	Continued from page 96 sauce. When informed that the pork had no taste that resemble these flavors, the cook indicated that she probably could add more brown sugar. The chicken recipe called for breadcrumbs and parmesan cheese. There were no visible breadcrumbs noted on observation of the chicken or when tasting the chicken. There was no taste of parmesan cheese to the chicken. Both the Food Service Director and the cook indicated that they do not use salt to flavor due to cardiac diets and salt if offered and placed on the trays. 28 Pa. Code 211.6(b) Dietary Services.	F 0804		
F 0810 SS=D		F 0810		

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F 0810 SS=D	Continued from page 97 483.60(g) Assistive Devices - Eating Equipment/Utensils §483.60(g) Assistive devices The facility must provide special eating equipment and utensils for residents who need them and appropriate assistance to ensure that the resident can use the assistive devices when consuming meals and snacks. This REQUIREMENT is not met as evidenced by:	F 0810	1. The identified concern for R69 was immediately corrected. 2. Residents requiring adaptive utensils with meal set up will be identified on the meal ticket and a task in the nurse aide care plan will be generated. 3. The Director of Nursing or designee will provide educated to nursing staff on the process to identify residents that require adaptive utensils for meals. 4. The Director of Nursing or designee will perform adaptive utensil audits at meal times weekly x 4 and monthly x2. Findings will be reported to the Quality Assurance Committee.	Completion Date: 02/20/2025 Status: APPROVED Date: 02/03/2025

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F 0810 SS=D	<p>Continued from page 98</p> <p>Based on clinical record reviews, observations, and staff interviews, it was determined that the facility failed to provide adaptive eating equipment as ordered by the physician for one of 31 residents reviewed (Resident 69).</p> <p>Findings include:</p> <p>A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 69, dated November 20, 2024, indicated that the resident was cognitively intact and required set-up assistance from staff with eating. Physician's orders for Resident 69, dated November 4, 2024, included an order for built-up utensils for all meals. A care plan, dated June 20, 2024, indicated that the resident was to utilize built-up utensils.</p> <p>Observations of Resident 69 during the breakfast meal on October 9, 2024, at 8:26 a.m. revealed that the resident was in his room eating his meal with regular utensils and did not have built-up utensils.</p>	F 0810		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395840	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/09/2025
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F 0810 SS=D	Continued from page 99 The resident's meal ticket included built-up utensils. Interview with Nurse Aide 9 at that time confirmed that Resident 69 did not have built-up utensils and should have had them. Interview with the Director of Nursing on January 9, 2025, at 12:56 p.m. confirmed that Resident 69 should have had built-up utensils if they were ordered and care planned. 28 Pa. Code 211.12(d)(3)(5) Nursing Services.	F 0810		
F 0812 SS=E		F 0812		

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F 0812 SS=E	Continued from page 100 483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by:	F 0812	1. The ice scoop was immediately removed from the chest. The thawing process of the chicken cannot be corrected. 2. The Dietary Manager or designee will audit all ice chests to ensure that the ice scoops are stored correctly. The Dietary Manager or designee will audit thawing processes for chicken for proper procedure. 3. The Dietary Manager or designee will re-educate all nursing staff and dietary aides on proper storage of ice scoops. The Dietary Manager or designee will re-educate all dietary staff on the proper thawing technique for frozen chicken. 4. The Dietary Manager or designee will perform ice chest audits for proper storage of scoops weekly x 4 and monthly x2. The Dietary Manager or designee	Completion Date: 02/20/2025 Status: APPROVED Date: 02/03/2025

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F 0812 SS=E	Continued from page 101	F 0812	will perform thawing of food item audits weekly x4 and monthly x2. Findings will be reported to the Quality Assurance Committee.		

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F 0812 SS=E	Continued from page 102 Based on review of policies, as well as observations and staff interviews, it was determined that the facility failed to ensure that food was stored and served in accordance with professional standards for food service safety. Findings include: The facility's policy regarding food preparation, dated August 28, 2024, revealed that the dinning services director/cook is responsible to ensure that proper practice is utilized in thawing frozen foods. One method is that frozen foods are completely submerged under cold water (70 degrees or below) that is running fast enough to agitate and float off loose ice particles. Observations in the kitchen on January 7, 2025, at 8:49 a.m. revealed a large bag of chicken in a sealed plastic bag in the kitchen sink submerged in water. No running water was observed. Observations in the kitchen on January 7, 2025, at 9:06 a.m.	F 0812		

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F 0812 SS=E	Continued from page 103 revealed a large bag of chicken in a sealed plastic bag in the kitchen sink submerged in water. No running water was observed. Interview with the Food Service Director at that time indicated that they usually put the frozen chicken in the cooler to thaw, but it was needed to prep for a meal today, so the cook placed it in cold water to thaw. She indicated that this was the process. Interview with the Food Service Director on January 8, 2025, at 12:10 p.m. indicated that the sink fills up and the water is shut so it does not overflow and is turned back on. She indicated that the temperature of the water was below 70 degrees. She indicated that she was not sure if the cook took the temperature of the water or not, but she would check. At that time, she was not able to confirm if the chicken had been thawed with running cold water as per the policy. Observations of the nourishment station on the Third-floor South side on January 8, 2025, at 9:13 a.m. revealed a cooler with some ice in it and the ice scoop was lying in the ice.	F 0812		

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F 0812 SS=E	Continued from page 104 Interview with Nurse Aide 10 on January 8, 2025, at 9:25 a.m. confirmed that the ice scoop should not have been lying inside the cooler in the ice. She indicated that some coolers have a fixed container on the coolers to place the scoop in. That cooler did not have that. There was a plastic container with a scoop in it observed under the cart the cooler was on. She does not know why there were two scoops in there. She indicated that they get the ice from the ice machine in the nourishment station on the East side of the Third floor. Interview with the Director of Nursing on January 8, 2025, at 10:45 a.m. confirmed that the ice scoop should not have been in the cooler in the ice. 28 Pa. Code 211.6(f) Dietary Services.	F 0812		
F 0867 SS=D		F 0867		

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F 0867 SS=D	Continued from page 105 483.75(c)(d)(e)(g)(2)(i)(ii) QAPI/QAA Improvement Activities §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.71 and including how such information will be used to develop and monitor performance indicators. §483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation. §483.75(c)(4) Facility adverse event monitoring, including	F 0867	1. All areas identified during this annual survey have submitted plans of correction. All identified resident concerns that are correctable will be corrected. 2. Audits will be completed for all federal regulations identified as not in compliance to ensure any additional residents have been identified and corrective measures have been implemented. 3. All submitted plans of correction have specific education/re-educations listed for all appropriate disciplines that will be provided by the listed facility employees. The Executive Director will re-educate the QAPI committee of the expectations of the facility and role of the committee per federal regulation. 4. Audits for each citation will be submitted to the Quality Assurance	Completion Date: 02/20/2025 Status: APPROVED Date: 02/03/2025

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F 0867 SS=D	Continued from page 106 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	Committee for review. The Executive Director or designee will audit the QAPI minutes monthly x3 to ensure all audits have been submitted and all identified areas have been addressed.	

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F 0867 SS=D	Continued from page 107 incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care. §483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility. §483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.71. Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section. §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must:	F 0867		

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F 0867 SS=D	Continued from page 108 (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=D	Continued from page 109 Based on review of the facility's plans of correction for previous surveys, and the results of the current survey, it was determined that the facility's Quality Assurance Performance Improvement (QAPI) committee failed to correct quality deficiencies and ensure that plans to improve the delivery of care and services effectively addressed recurring deficiencies. Findings include: The facility's deficiencies and plans of corrections for a State Survey and Certification (Department of Health) survey ending February 29, 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 9, 2025, identified repeated deficiencies related the accuracy of Minimum Data Set (MDS) assessments (mandated assessment of a resident's abilities and care needs), to care plan timing and revision, the failure to provide quality of	F 0867		

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F 0867 SS=D	Continued from page 110 care, issues with the accountability of controlled medications (drugs with the potential to be abused), storage and labeling of medications, and ensuring that food was properly prepared and served. The facility's plan of correction for a deficiency regarding the accuracy of assessments, cited during the survey ending February 29, 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 F641, revealed that the facility's QAPI committee failed to successfully implement their plan to ensure ongoing compliance with regulations regarding the accuracy of assessments. The facility's plan of correction for a deficiency regarding care plan timing and revision, cited during the survey ending February 29, 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 F657, revealed that the facility's QAPI	F 0867		

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F 0867 SS=D	Continued from page 111 committee failed to successfully implement their plan to ensure ongoing compliance with regulations regarding care plan timing and revision. The facility's plan of correction for a deficiency regarding quality of care, cited during the survey ending February 29, 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 F684, revealed that the facility's QAPI committee failed to successfully implement their plan to ensure ongoing compliance with regulations regarding quality of care. The facility's plan of correction for a deficiency regarding the failure to account for controlled medications, cited during the survey ending February 29, 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	F 0867		

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F 0867 SS=D	Continued from page 112 correcting deficient practices related to the accountability of controlled medications. The facility's plans of correction for deficiencies regarding storage and labeling of medications, cited during the survey ending February 29, 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 F761, revealed that the facility's QAPI committee failed to maintain compliance with the regulation regarding storage and labeling of medications. The facility's plan of correction for a deficiency regarding appropriate food preparation and serving, cited during the survey ending February 29, 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 F812, revealed that the facility's QAPI committee was ineffective in maintaining compliance	F 0867		

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F 0867 SS=D	Continued from page 113 with the regulation regarding food preparation and serving. Refer to F641, F657, F684, F755, F761, F812. 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 114 483.80(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	<ol style="list-style-type: none"> 1. The identified concern for R50 was immediately corrected. 2. The Director of Nursing or designee will audit all residents to ensure that appropriate enhanced barrier precaution (EBP) signage is present for the affected residents. 3. The Director of Nursing or designee will re-educate all staff on appropriate placement of enhanced barrier precaution (EBP) signage. Education will include when residents require enhanced barrier precautions that signage is put in place in addition to appropriate personal protective equipment (PPE). 4. The Director of Nursing or designee will audit residents to ensure that appropriate enhanced barrier precaution (EBP) signage is present outside the room in addition to appropriate PPE of the affected residents weekly x4 then monthly x2. All findings will be submitted to the Quality Assurance Committee. 	Completion Date: 02/20/2025 Status: APPROVED Date: 02/03/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395840	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/09/2025	
NAME OF PROVIDER OR SUPPLIER: PATRIOT VILLAGE STATE LICENSE NUMBER: 167902		STREET ADDRESS, CITY, STATE, ZIP CODE: 495 WEST PATRIOT STREET SOMERSET, PA 15501		
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F 0880 SS=D	Continued from page 115 (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by:	F 0880		

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F 0880 SS=D	Continued from page 116	F 0880		

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F 0880 SS=D	Continued from page 117 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 31 residents reviewed (Resident 50). 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 118 morbidity and mortality and increased healthcare costs. Enhanced Barrier Precautions (EBP) 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 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, dated August 28, 2024, revealed that EBP's are indicated (when contact precautions do not otherwise apply) for residents with wounds and/or indwelling medical devices regardless of MDRO colonization. Wounds generally include chronic wounds (such as pressure ulcers, diabetic foot ulcers, venous stasis ulcers, and	F 0880		

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F 0880 SS=D	Continued from page 119 unhealed surgical wounds). Indwelling medical devices include central lines, urinary catheters feeding tubes, and tracheostomies. Signs are posted in the door or on the wall outside of the resident's room indicating the type of precautions and PPE required. PPE is available inside of the residents' rooms. An admission MDS assessment for Resident 50, dated December 9, 2024, revealed that the resident had mild cognitive impairment, was understood and able to understand others, required substantial assist with bed mobility, was dependent for transfers, was not ambulatory, had an indwelling catheter (a thin, flexible tube inserted into the bladder to drain urine from the bladder), was frequently incontinent of bowel, had two Stage 2 pressure ulcers (pressure wound with skin loss) on admission, had a surgical wound and wound infection, had a pressure-relieving device to bed and chair, and received pressure ulcer care and surgical wound care. A care plan for Resident 50, dated December 3, 2024, revealed that the resident had a sacral	F 0880		

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F 0880 SS=D	Continued from page 120 surgical wound with EBP and a care plan, dated December 3, 2024, for an indwelling catheter with EBP. A physician's order for Resident 50, dated December 2, 2024, included an order for an indwelling catheter, 16 French (size) with a 10 cubic centimeters (cc) balloon (located on the bladder end of the catheter and filled with sterile water to hold the tube in place). Physician's orders for Resident 50, dated December 3, 2024, included an order to cleanse the right and left buttocks with warm soap and water, pat dry, apply zinc oxide (topical medication to treat skin irritations) and cover with comfort foam twice daily. Physician's orders for Resident 50, dated December 3, 2024, included an order to apply betadine (an solution used to treat and prevent infection) to the intergluteal cleft and buttocks flap closure with sutures and cover with comfort foam twice daily. Observations during the facility tour on January 7,	F 0880		

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F 0880 SS=D	Continued from page 121 2025, at 2:20 p.m. revealed no signage on Resident 50's door or on the wall outside the resident's room to indicate that the resident was on EBP. Observations on January 8, 2025, at 9:02 a.m. revealed that the resident sitting in her wheelchair in her room with an indwelling catheter bag hanging under wheelchair and no signage on the resident's door or on the wall outside the resident's room to indicate that the resident was on EBP. Interview with the Director of Nursing on January 8, 2025, at 2:18 p.m. confirmed that Resident 50 had an unhealed surgical wound and an indwelling catheter and that signage should have been visibly posted on the resident's door or outside the resident's room to indicate that the resident was on EBP. 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		

Pennsylvania Department of Health

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P 5520	<p>Nursing services.</p> <p>(3) Effective July 1, 2024, a minimum of 1 nurse aide per 10 residents during the day, 1 nurse aide per 11 residents during the evening, and 1 nurse aide per 15 residents overnight.</p> <p>This REGULATION is not met as evidenced by:</p>	P 5520	<p>The nursing schedule will be reviewed by the scheduler and Director of Nursing to ensure that nursing assistant ratios are met prior to posting of the schedule. The daily schedule will be reviewing during the daily stand up meeting.</p> <p>In the event of call-offs by staff, all other staff will be contacted to cover any open shifts to ensure ratios are met.</p> <p>The staffing tool audit will be completed daily for 4 weeks, then 3 times a week for 3 weeks, then 2 times a week for 2 weeks then weekly ongoing, to ensure that nursing ratios are met for the daylight, evening and overnight shifts.</p> <p>The audit will be monitored by the Director of Nursing or Designee.</p>	<p>Completion Date: 02/20/2025 Status: APPROVED Date: 02/03/2025</p>
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE:		(X6) DATE:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395840	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/09/2025
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P 5520	Continued from page 1 Based on review of nursing schedules, review of staffing information furnished by the facility, and staff interview, it was determined that the facility failed to provide one nurse aide (NA) per 10 residents on the day shift for two of 21 days, and failed to ensure a minimum of one NA per 15 residents on the night shift for five of 21 days reviewed for November 24 through 30, 2024; December 15 through 21, 2024; and January 2 through 8, 2025. Findings include: Review of facility census data revealed: On November 24, 2024, the facility census was 75, during the day shift, which required 7.50 NA's during the day shift. Review of the nursing time schedules revealed 7.20 NA's provided care on the day shift. On November 29, 2024, the facility census was 75 during the day shift, which required 7.50 NA's;	P 5520		

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P 5520	Continued from page 2 however, review of the time schedules revealed that 7.02 NA's provided care during the day shift. On November 26, 2024, the facility census was 78 during the night shift, which required 5.20 NA's; however, review of the time schedules revealed that 4.00 NA's provided care during the night shift. On November 28, 2024, the facility census was 76 during the night shift, which required 5.07 NA's; however, review of the time schedules revealed that 4.04 NA's provided care during the night shift. On November 30, 2024, the facility census was 77 during the night shift, which required 5.13 NA's; however, review of the time schedules revealed that 4.35 NA's provided care during the night shift. On December 21, 2024, the facility census was 76 during the night shift, which required 5.07 NA's; however, review of the time schedules revealed that 4.42 NA's provided care during the night shift.	P 5520		

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P 5520	Continued from page 3 On January 7, 2025, the facility census was 77 during the night shift, which required 5.13 NA's; however, review of the time schedules revealed that 5.08 NA's provided care during the night shift. However, there were no additional excess higher-level staff were available to compensate for these deficiencies. Interview with the Nursing Home Administrator on January 9, 2025, at 12:20 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		

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P 5530	Continued from page 4 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	The nursing schedule will be reviewed by the scheduler and Director of Nursing to ensure that nursing assistant ratios are met prior to posting of the schedule. The daily schedule will be reviewing during the daily stand up meeting. In the event of call-offs by staff, all other staff will be contacted to cover any open shifts to ensure ratios are met. The staffing tool audit will be completed daily for 4 weeks, then 3 times a week for 3 weeks, then 2 times a week for 2 weeks then weekly ongoing, to ensure that nursing ratios are met for the daylight, evening and overnight shifts. The audit will be monitored by the Director of Nursing or Designee.	Completion Date: 02/20/2025 Status: APPROVED Date: 02/03/2025

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P 5530	Continued from page 5 Based on review of nursing schedules, review of staffing information furnished by the facility, and staff interviews, it was determined that the facility failed to ensure a minimum of one licensed practical nurse (LPN) per 40 residents on the overnight shifts for three of 21 days reviewed for November 24 through 30, 2024; December 15 through 21, 2024; and January 2 through 8, 2025. Findings include: Review of facility census data revealed: On November 26, 2024, the facility's census was 78 during the night shift, which required 1.95 LPN's; however, review of the time schedules revealed that 1.93 LPN's provided care during the night shift. On November 27, 2024, the facility's census was 77 during the night shift, which required 1.93 LPN's; however, review of the time schedules revealed that 1.60 LPN's provided care during the night shift.	P 5530		

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P 5530	Continued from page 6 On November 30, 2024, the facility's census was 77 during the night shift, which required 1.93 LPN's; however, review of the time schedules revealed that 1.05 LPN's provided care during the night shift. However, there were no additional excess higher-level staff were available to compensate for these deficiencies. Interview with the Nursing Home Administrator on January 9, 2025, at 12:20 p.m. confirmed that the facility did not meet the required LPN-to-resident staffing ratios for the days listed above.	P 5530		



Certified End Page

PATRIOT VILLAGE

STATE LICENSE NUMBER: 167902

SURVEY EXIT DATE: 01/09/2025

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


Jeanne Parisi
Deputy Secretary for Quality Assurance


Debra L. Bogen, MD, FAAP
Secretary of Health



**Pennsylvania
Department of Health**

THIS IS A CERTIFICATION PAGE

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