

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395845	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/24/2025
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NAME OF PROVIDER OR SUPPLIER: CRANBERRY PLACE STATE LICENSE NUMBER: 381602	STREET ADDRESS, CITY, STATE, ZIP CODE: 5 ST. FRANCIS WAY CRANBERRY TOWNSHIP, PA 16066
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F 0000	INITIAL COMMENT	F 0000		
F 0550	Based on a Medicare/Medicaid Recertification survey, Complaint survey, State Licensure survey, and a Civil Rights Compliance survey, completed on January 24, 2025, it was determined that Cranberry Place 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		
SS=D				

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	Resident R94 remains in her current bed/ accepted another bed/ was provided a window bed on 1/24/2025. The facility has no other current residents with voluntary outstanding bed requests. The NHA/Designee will educate Social Services and Admission Director on resident rights and the facility procedure of making room moves in a prompt manner. The NHA/Designee will audit any voluntary room move requests weekly x4 and monthly x2 to ensure that moves are completed in a timely manner. Results to be reviewed through QAPI for further recommendation.	Completion Date: 03/13/2025 Status: APPROVED Date: 02/24/2025

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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		

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F 0550 SS=D	<p>Continued from page 3</p> <p>Based on review of residents clinical record, resident and staff interview it was determined that the facility failed to meet resident rights for one of 10 residents reviewed (Resident R94).</p> <p>Findings include:</p> <p>Resident R94 was admitted on 11/7/24.</p> <p>Resident R94 MDS (minimum data set - a periodic assessment of resident needs) dated 11/13/24, indicated diagnoses diabetes mellitus (a group of diseases that result in too much sugar in the blood), anxiety (a mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities), and depression (mood disorder that causes a persistent feeling of sadness and loss of interest and can interfere with one's daily life).</p> <p>During an interview on 1/23/25, Resident R94 indicated that they were interested in switching beds from the door bed, to the window bed (which was</p>	F 0550		

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F 0550 SS=D	<p>Continued from page 4</p> <p>empty due to roommate being discharged). Resident R94 indicated that they spoke with staff about it and the facility was going to switch Resident R94 to the window bed.</p> <p>During an interview on 1/23/25, at 11:16 a.m. Director of Social Services Employee E2, confirmed that the facility was aware of the request and was going to honor the request.</p> <p>During an observation on 1/24/25, at 9:00 a.m. Resident R94 indicated that the switch to the window bed did not take place as the facility indicated, and they got a new roommate who was in the window bed.</p> <p>During an interview on 1/24/25, at Nursing Home Administrator confirmed that the facility failed to move Resident R94 to the window bed.</p> <p>28 Pa. Code 201.29 (j) Resident rights. 28 Pa. Code 201.18 (e) (1)(2)(3)(6)Management.</p>	F 0550		

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F 0578 SS=D	<p>483.10(c)(6)(8)(g)(12)(i)-(v) Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir</p> <p>§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.</p> <p>§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.</p> <p>§483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives).</p> <p>(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.</p> <p>(ii) This includes a written description of the facility's policies to implement advance directives and applicable State law.</p> <p>(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.</p>	F 0578	<p>Residents R70 and R77 will be offered the opportunity to complete an Advanced Directive.</p> <p>All residents in the facility will be reviewed to ensure an advanced directive is in place or has been offered to complete one by social services/designee. The facility social services and Admission Director will be educated on requirements to have the opportunity to complete an advance directive. Social Service will offer Advance Directive Apon admission and document refusals. Audits of all new admissions will be completed by the SSD/Designee weekly x 4 then monthly x 2 months, to ensure residents are provided the opportunity to complete advanced directives. Audit results will be reviewed through QAPI for further recommendation.</p>	<p>Completion Date: 03/13/2025 Status: APPROVED Date: 02/24/2025</p>

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F 0578 SS=D	Continued from page 6 (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 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		

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F 0578 SS=D	Continued from page 7 Based on review of facility policy, clinical records, and staff interview, it was determined that the facility failed to provide documentation of advanced directives or given the opportunity to formulate an advance directive (a written instruction such as a living will or durable power of attorney for health care for when the individual is incapacitated) for two of four residents reviewed (Resident R70, and R77). Findings include: A review of the facility policy "Advanced Directives" last reviewed 8/24, indicated that the resident has the right to formulate an advanced directive, including the right to accept or refuse medical or surgical treatment. Advanced directives are honored in accordance with state law and facility policy. The resident or representative is provided with written information concerning the right to formulate an advanced directive in a manner that is easily understood.	F 0578		

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F 0578 SS=D	<p>Continued from page 8</p> <p>Review of Resident R70's clinical record indicated the resident was admitted to the facility on 6/26/23.</p> <p>Review of Resident R70's MDS dated 11/9/24, indicated diagnoses of cancer, depression, and peripheral vascular disease (PVD, circulatory condition in which narrowed blood vessels reduce blood flow to the limbs).</p> <p>A review of the clinical record failed to reveal an advanced directive or documentation that Resident R70 was given the opportunity to formulate an Advanced Directive.</p> <p>Review of Resident R77's clinical record indicated the resident was admitted to the facility on 12/6/23.</p> <p>Review of Resident R77's MDS dated 12/2/24, indicated diagnoses of cancer, high blood pressure, and diabetes (a metabolic disorder in which the body has high sugar levels for prolonged periods of time).</p>	F 0578		

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F 0578 SS=D	Continued from page 9 A review of the clinical record failed to reveal a copy of Resident R77's Advanced Directives. During an interview on 1/24/25 at 12:05 p.m. Registered Nursed Employee E1 stated, "I looked in both residents ' charts and could not find Advanced Directives or documentation that the opportunity was given to formulate them". During an interview on 1/24/25, at 3:00 p.m. the Director of Nursing confirmed that the facility failed to provide documentation of advanced directives or given the opportunity to formulate an advance directive for two of four residents reviewed (Resident R70, and R77). 28 Pa. Code: 201.29(b)(d)(j) Resident rights.	F 0578		

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F 0580 SS=D	483.10(g)(14)(i)-(iv)(15) Notify of Changes (Injury/Decline/Room, etc.) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law	F 0580	R50 no longer resides in the facility. A retroactive review of all residents with tube feedings will be completed to ensure that any required notifications have been completed. The DON/Designee will educate all licensed nursing staff on the "Guidelines for Notifying Physicians of Clinical Problems" policy for physician notification. The DON or designee will audit all residents with tube feeds for physician notification of refusals daily x3, then five residents twice weekly x 3, then weekly 8 weeks. Audit results will be reviewed through QAPI for further recommendation.	Completion Date: 03/13/2025 Status: APPROVED Date: 02/24/2025

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F 0580 SS=D	Continued from page 11 or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by:	F 0580		

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F 0580 SS=D	Continued from page 12 Based on review of facility policy, clinical records and staff interview, it was determined that the facility failed to notify the physician of a resident's refusal of tube feedings for one of four residents (Resident R50). Findings include: Review of the facility policy "Guidelines for Notifying Physicians of Clinical Problems" last reviewed 8/24, indicated medical care problems are communicated to the medical staff in a timely efficient and effective manner. Review of the facility policy "Enteral Tube Feeding via Continuous Pump" last reviewed 8/24, indicates to report negative consequences of tube use (e.g., agitation, depression, self-extubating, infections etc.) to the supervisor and attending physician. Review of the facility policy "Enteral Feedings-Safety Precautions" last reviewed 8/24, indicates report unusual findings and/or signs of	F 0580		

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F 0580 SS=D	Continued from page 13 complications to the physician. Review of the clinical record indicated that Resident R50 was admitted to the facility on 8/1/24, with the diagnosis of quadriplegia (paralysis that affects all limbs and body from the neck down) depression, and anxiety. Review of Resident R50's medication administration record (MAR) dated 1/25, indicates enteral feed order Nutren 2.0 (formula for those who need high calories), 265 cubic centimeter (cc-unit of volume) intermittent feeding four times a day via pump start day 12/27/24. Discontinued 1/10/25. Review of Resident R50's MAR dated 1/25, indicates eternal feed order Nutren 2.0, 250cc intermittent feeding four times a day via pump start date 1/10/25. Review of Resident R50's MAR for 1/25, indicated the following dates marked with the number two (2) indicating refused: 1/1/25, at 8:00 a.m., 1/4/25, at	F 0580		

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F 0580 SS=D	Continued from page 14 8:00 a.m., 1/5/25, at 8:00 a.m., 1/7/25, at 8:00 a.m., 1/8/25, at 5:00 p.m. and 9:00 p.m., 1/10/25, at 9:00 p.m., 1/11/25, 9:00 p.m., 1/12/25, at 5:00 p.m., 1/14/25, at 8:00 a.m. and 5:00 pm., 1/16/25, at 9:00 p.m., 1/18/25, at 4:00 p.m., 1/19/24 at 8:00 a.m. Review of Resident R50's nursing progress notes failed to include physician notification of the refusal of above enteral tube feedings. During an interview completed on 1/23/25, at 2:44 p.m. the Director of Nursing (DON) confirmed the facility failed to notify the physician of a resident's refusal of tube feedings for Resident R50. 28. Pa. Code: 211.10(a)(c)(d) Resident care policies. 28 Pa. Code: 211.12(d)(1)(2)(3)(5) Nursing services. 28 Pa. Code: 201.14(a)(c)(d)(e) Responsibility of licensee.	F 0580		

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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 0580 SS=D	Continued from page 15 28 Pa. Code: 201.29(a)(b)(c)(d)(j)(m) Resident rights.	F 0580		
F 0582 SS=D		F 0582		

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F 0582 SS=D	Continued from page 16 483.10(g)(17)(18)(i)-(v) Medicaid/Medicare Coverage/Liability Notice §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation	F 0582	Resident R27 is in facility. A one-week retroactive review of all notices signed will be completed to ensure that signors have the capacity to consent, and any residents that are unable to consent have been signed by the party responsible. The NHA or designee will educate social services and RNAC's on Notice of Resident Rights and Responsibilities policy. The SSD or designee will audit all ABN/NOMNC's signed to ensure that the appropriate responsible party is receiving and signing the form. Monthly X 3 months. Audit results will be reviewed through QAPI for further recommendation.	Completion Date: 03/13/2025 Status: APPROVED Date: 02/24/2025

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F 0582 SS=D	Continued from page 17 of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by:	F 0582		

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F 0582 SS=D	Continued from page 18 Based on a review of facility admission documents and staff interview, it was determined that the facility failed to ensure resident rights to make informed decisions and choices about important aspects of residents' health, safety and welfare by making certain residents understand the Notice of Medicare Non-Coverage (NOMNC) and Skilled Nursing Facility Advanced Beneficiary Notice of Non-coverage (SNF ABN) forms and failed to ensure the agreement is explained to the resident and his or her representative in a form and manner that he or she understands for one of three residents (Resident R27). Findings include: Review of the Resident Assessment Instrument 3.0 User's Manual effective October 2024 indicated that a Brief Interview for Mental Status (BIMS), is a screening test that aides in detecting cognitive impairment. The BIMS total score suggests the following distributions: 13-15: cognitively intact	F 0582		

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F 0582 SS=D	Continued from page 19 8-12: moderately impaired 0-7: severe impairment Review of Resident R27's admission record indicated the resident was admitted to the facility 7/15/24. Review of Resident R27's demographic information available in the electronic medical record indicated that Resident R27's daughter was her responsible party. Review of the Minimum Data Set (MDS - periodic assessment of care needs) dated 7/17/24, included diagnoses of chronic obstructive pulmonary disease, myopathy (disease of the muscle), and diabetes mellitus (disease that affects how the body uses blood sugar). Review of Section C: Cognitive Patterns, Questions C0500 "BIMS Summary Score" revealed Resident R27's score to be "11", moderately impairment. Review of the NOMNC and SNF ABN form dated	F 0582		

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F 0582 SS=D	Continued from page 20 8/16/24, revealed that it was signed by Resident R27. During an interview on 1/24/25, at 8:33 a.m., the Nursing Home Administrator (NHA) confirmed the facility failed to ensure the NOMNC and SNF ABN forms are explained to the resident and his or her representative in a form and manner that he or she understands for one of three residents (Resident R27). 28 Pa. Code 201.14(a) Responsibility of Licensee. 28 Pa. Code 201.18(b)(2) Management. 28 Pa. Code 201.29(a) Resident Rights.	F 0582		
F 0585 SS=D		F 0585		

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F 0585 SS=D	Continued from page 21 483.10(j)(1)-(4) Grievances §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance	F 0585	Grievance forms were placed, and official contact information postings were immediately updated at all grievance boxes on all floors upon identification by surveyor. Residents will be notified and reoriented to the grievance procedure, grievance official, grievance box accessibility, availability of forms and response times at the next scheduled resident council meeting. Residents who do not attend resident council will be notified of the grievance procedure in writing or by the activities department. Anonymous grievance box is located in the dining room. Social Services and Activities staff will be educated by the NHA/Designee on the grievance policy and procedure and federal guidelines at F585 Grievances. Audits will be completed by the NHA or designee weekly x 4 weeks, then monthly x 2 months to ensure boxes, postings, and forms are available for resident use. All results to be reviewed through QAPI for further recommendation.	Completion Date: 03/13/2025 Status: APPROVED Date: 02/24/2025

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F 0585 SS=D	Continued from page 22 can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the	F 0585		

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F 0585 SS=D	Continued from page 23 date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by:	F 0585		

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F 0585 SS=D	Continued from page 24 Based on review of facility policy, observations, resident and staff interviews it was determined that the facility failed to make certain that a posted grievance policy and procedure met federal guidelines for three of three nursing units and common areas. Findings include: The facility "Grievance Program (Concern and Comment)" dated 8/20/24, indicated "To help guide our communities in the grievance process and ensure that a thorough, complete, and accurate investigation has been completed to the best of our knowledge in accordance with F585 483.10(j)(1)(2)(3) and (4)." Resident group interview on 1/22/25, at 3:00 p.m. resident indicated they were unaware of the grievance policy, and procedure how they could file anonymously. During a tour on 1/23/25, at 9:57 a.m. on 3 nursing units and common areas to include the main dining	F 0585		

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F 0585 SS=D	Continued from page 25 room, nursing unit lounge areas, failed to have a complete grievance policy and procedure posted and failed to have a posting with the grievance officer address included on the posting, failed to include how to file anonymously, failed to include the process (time frame to get response to grievance). During observations on 1/23/25, at 10:08 a.m. with Director of Social Service Employee E2, confirmed that there was not information nor a place to file anonymously, that the process for grievances was not posted, facility failed to make certain that a posted grievance policy and procedure met federal guidelines for three of three nursing units and common areas. 28 Pa. Code 201.29(1) Resident rights. 28 Pa. Code 201.19(e)(1)Management.	F 0585		
F 0622 SS=E		F 0622		

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F 0622 SS=E	Continued from page 26 483.15(c)(1)(i)(ii)(2)(i)-(iii) Transfer and Discharge Requirements §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D) The health of individuals in the facility would otherwise be endangered; (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or (F) The facility ceases to operate. (ii) The facility may not transfer or discharge the resident	F 0622	Residents R70 remains in facility with no negative outcomes, R76 remain in facility with no negative outcomes, R115 has been discharged. A one-week retroactive review of all facility-initiated transfers will be followed by telephone to ensure that all necessary resident information was communicated to the receiving health care provider and provided if necessary. The DON/Designee will educate all licensed nursing a on the necessary information requirement found at F622 for transfers to a receiving healthcare provider. The NHA or designee will audit all facility-to-facility transfers to ensure all resident information requirements were met daily x3, then five resident facility-to-facility transfers weekly x8. Results will be reviewed through QAPI for further recommendation.	Completion Date: 03/13/2025 Status: APPROVED Date: 02/24/2025

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F 0622 SS=E	Continued from page 27 while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose. §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i) (A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (i) Documentation in the resident's medical record must include: (A) The basis for the transfer per paragraph (c)(1)(i) of this section. (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). (ii) The documentation required by paragraph (c)(2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and	F 0622		

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F 0622 SS=E	Continued from page 28 (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. This REQUIREMENT is not met as evidenced by:	F 0622		

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F 0622 SS=E	<p>Continued from page 29</p> <p>Based on review of clinical records and staff interviews, it was determined that the facility failed to make certain that the necessary resident information was communicated to the receiving health care provider for three of four residents sampled with facility-initiated transfers (Residents R70, R76, and R115).</p> <p>Findings include:</p> <p>Review of the clinical record indicated Resident R70 was admitted to the facility on 6/26/23.</p> <p>Review of Resident R70's Minimum Data Set (MDS - a periodic assessment of care needs) dated 11/9/24, indicated diagnoses of cancer (abnormal cells form tumors in healthy tissue), depression, and peripheral vascular disease (PVD, circulatory condition in which narrowed blood vessels reduce blood flow to the limbs).</p> <p>Review of Resident R70's clinical record revealed that the resident was transferred to the hospital on</p>	F 0622		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395845	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/24/2025
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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 0622 SS=E	Continued from page 30 12/31/24. Review of Resident R70's clinical record revealed no documented evidence that the facility had communicated specific information to the receiving health care provider for the residents transfer, which included the resident's care plan goals, advanced directive information, specific instructions for ongoing care, resident representative information, and all information necessary to meet the resident's specific needs at the receiving facility. Review of the clinical record indicated Resident R76 was admitted to the facility on 9/26/23. Review of Resident R76's MDS dated 11/12/24, indicated diagnoses of high blood pressure, depression, and diabetes (a metabolic disorder in which the body has high sugar levels for prolonged periods of time). Review of Resident 76's clinical record revealed that the resident was transferred to the hospital on	F 0622		

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F 0622 SS=E	Continued from page 31 8/25/24. Review of Resident R76's clinical record revealed no documented evidence that the facility had communicated specific information to the receiving health care provider for the residents transfer, which included the resident's care plan goals, advanced directive information, specific instructions for ongoing care, resident representative information, and all information necessary to meet the resident's specific needs at the receiving facility. Review of the clinical record indicated Resident R115 was admitted to the facility on 10/24/24, with the diagnoses of renal insufficiency (condition where the kidneys lose the ability to remove waste and balance fluids), atrial fibrillation (irregular heart rhythm), and heart failure (heart doesn't pump blood as well as it should). Review of the clinical record indicated Resident R115 was transferred to the hospital on 10/28/24.	F 0622		

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NAME OF PROVIDER OR SUPPLIER: CRANBERRY PLACE STATE LICENSE NUMBER: 381602		STREET ADDRESS, CITY, STATE, ZIP CODE: 5 ST. FRANCIS WAY CRANBERRY TOWNSHIP, PA 16066		
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F 0622 SS=E	Continued from page 32 Review of Resident R115's clinical record revealed no documented evidence that the facility had communicated specific information to the receiving health care provider for the residents transfer, which included the resident's care plan goals, advanced directive information, specific instructions for ongoing care, resident representative information, and all information necessary to meet the resident's specific needs at the receiving facility. During an interview on 1/24/25, at 9:40 a.m. the Nursing Home Administrator stated, "We send the paperwork with the resident but as far as documentation to prove what was sent, that we don't have." During an interview on 1/24/25, at 3:00p.m. the Director of Nursing confirmed that the facility failed to make certain that the necessary resident information was communicated to the receiving health care provider for three of four residents sampled with facility-initiated transfers (Residents R70, R76, and R115).	F 0622		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395845	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/24/2025
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F 0622 SS=E	Continued from page 33 28 Pa. Code: 201.14(a) Responsibility of licensee. 28 Pa. Code: 201.18(a)(b)(3) Management. 28 Pa. Code: 201.29(b)(d)(j) Resident rights. 28 Pa. Code: 211.12 (d)(1)(3)(5) Nursing services.	F 0622		
F 0625 SS=E		F 0625		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395845	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/24/2025	
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F 0625 SS=E	Continued from page 34 483.15(d)(1)(2) Notice of Bed Hold Policy Before/Upon Trnsfr §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by:	F 0625	Resident R70 returned to the facility 1/7/25. Resident R76 returned to the facility on 8/29/24. Resident R115 did not return to the facility. Residents were not charged any bed-hold fees and as a result had no negative outcome. A retroactive 14-day review of all hospital/leave transfers will be completed to ensure residents/representatives have been provided information regarding the facility bed-hold policy. The NHA or designee will educate all licensed nurses on the facility bed-hold policy and communicating information at the time of transfer. The NHA or designee will audit all hospital/leave transfers daily x3, then five resident transfers weekly x8. Results will be reviewed through QAPI for further recommendation.	Completion Date: 03/13/2025 Status: APPROVED Date: 02/24/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395845	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/24/2025
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F 0625 SS=E	Continued from page 35	F 0625		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395845	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/24/2025	
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F 0625 SS=E	Continued from page 36 Based on review of facility policy, clinical records, and resident and staff interview, it was determined that the facility failed to notify the resident or resident's representative of the facility bed-hold policy (an agreement for the facility to hold a bed for an agreed upon rate during a hospitalization) for three of four resident hospital transfers (Residents R70, R76, and R115). Findings Include: Review of the facility policy "Bed-Holds and Returns" dated August 2024, indicated all residents/representatives are provided written information regarding the facility bed-hold policies, which address holding or reserving a resident's bed during periods of absence (hospital or therapeutic leave). Residents are provided written information about these policies at least twice: well in advance of any transfer (e.g., in the admission packet); and at the time of transfer (or, if the transfer was an emergency, within 24 hours.)	F 0625		

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F 0625 SS=E	Continued from page 37 Review of the clinical record indicated Resident R70 was admitted to the facility on 6/26/23. Review of Resident R70's Minimum Data Set (MDS - a periodic assessment of care needs) dated 11/9/24, indicated diagnoses of cancer (abnormal cells form tumors in healthy tissue), depression, and peripheral vascular disease (PVD, circulatory condition in which narrowed blood vessels reduce blood flow to the limbs). Review of Resident R70's clinical record revealed that the resident was transferred to the hospital on 12/31/24, and returned on 1/7/25. Review of Resident R70's clinical record failed to include documented evidence that the resident or the resident's representative were provided with written information about the facility's bed hold policy at the time of the transfer to the hospital on 12/31/24. Review of the clinical record indicated Resident R76 was admitted to the facility on 9/26/23.	F 0625		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395845	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/24/2025
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F 0625 SS=E	Continued from page 38 Review of Resident R76's MDS dated 11/12/24, indicated diagnoses of high blood pressure, depression, and diabetes (a metabolic disorder in which the body has high sugar levels for prolonged periods of time). Review of Resident R76's clinical record revealed that the resident was transferred to the hospital on 8/25/24, and returned on 8/29/24. Review of Resident R76's clinical record failed to include documented evidence that the resident or the resident's representative were provided with written information about the facility's bed hold policy at the time of the transfer to the hospital on 8/25/24. Review of the clinical record indicated Resident R115 was admitted to the facility on 10/24/24, with the diagnoses of renal insufficiency (condition where the kidneys lose the ability to remove waste and balance fluids), atrial fibrillation (irregular heart rhythm), and heart failure (heart doesn ' t pump	F 0625		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395845	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/24/2025	
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F 0625 SS=E	Continued from page 39 blood as well as it should). Review of the clinical record indicated Resident R115 was transferred to the hospital on 10/28/24. Review of Resident R115's clinical record failed to include documented evidence that the resident or the resident's representative were provided with written information about the facility's bed hold policy at the time of the transfer to the hospital on 10/28/24. During an interview on 1/24/25, at 9:40 a.m. the Nursing Home Administrator confirmed the resident or resident's representative were not informed of the facility bed-hold policy at the time of transfer. Interview on 1/24/25, at 3:00 p.m. the Director of Nursing confirmed the facility failed to notify the resident or resident's representative of the facility bed-hold policy (an agreement for the facility to hold a bed for an agreed upon rate during a hospitalization) for three of four resident hospital transfers (Residents R70, R76, and R115).	F 0625		

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F 0625 SS=E	Continued from page 40 28 Pa. Code: 201.14(a) Responsibility of licensee. 28 Pa. Code: 201.18(a)(b)(3) Management. 28 Pa. Code: 201.29(b)(d)(j) Resident rights. 28 Pa. Code: 211.12 (d)(1)(3)(5) Nursing services.	F 0625		
F 0626 SS=D		F 0626		

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F 0626 SS=D	Continued from page 41 483.15(e)(1)(2) Permitting Residents to Return to Facility §483.15(e)(1) Permitting residents to return to facility. A facility must establish and follow a written policy on permitting residents to return to the facility after they are hospitalized or placed on therapeutic leave. The policy must provide for the following. (i) A resident, whose hospitalization or therapeutic leave exceeds the bed-hold period under the State plan, returns to the facility to their previous room if available or immediately upon the first availability of a bed in a semi-private room if the resident- (A) Requires the services provided by the facility; and (B) Is eligible for Medicare skilled nursing facility services or Medicaid nursing facility services. (ii) If the facility that determines that a resident who was transferred with an expectation of returning to the facility, cannot return to the facility, the facility must comply with the requirements of paragraph (c) as they apply to discharges. §483.15(e)(2) Readmission to a composite distinct part. When the facility to which a resident returns is a composite distinct part (as defined in § 483.5), the resident must be permitted to return to an available bed in the particular location of the composite distinct part in which he or she resided previously. If a bed is not available in that location at the time of return, the resident must be given the option to return to that location upon the first availability of a bed	F 0626	Resident R50 was not readmitted to the facility. Resident and mother's physiological and psychological behaviors that have impacted other residents and their rights. To ensure other residents were not affected by the deficient practice an audit of facility-initiated discharges of the past 30 days will be completed by the DON or designee. Regional Director of Clinical Support or designee will conduct education to the IDT Members: DON, Administrator, ADON, Social Service Director, the facility readmission policy and F-tag 626 requirements. The NHA or designee will audit all discharges to the hospital or LOA, and readmissions to ensure that all residents that discharged were allowed to return (or offered a bed hold per our Bed Hold policy). This will be done once a weekly x 3 months. Results will be reviewed at QAPI meeting.	Completion Date: 03/13/2025 Status: APPROVED Date: 02/24/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395845	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/24/2025
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F 0626 SS=D	Continued from page 42 there. This REQUIREMENT is not met as evidenced by:	F 0626		

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F 0626 SS=D	Continued from page 43 Based on clinical and facility record review, facility provided documents and staff interviews, it was determined that the facility failed to permit one of three residents who transferred to the hospital with the expectation of returning to the facility, return to the facility in a timely manner. (Resident R50) Findings include: Review of the facility policy "Bed-Holds and Returns dated August 2024, indicates residents and/or representatives are informed (in writing) of the facility and state (if applicable) bed hold policies. The written information regarding bed-holds provided to the residents/representatives explains in detail: a. The duration of a state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the facility. b. The reserve bed payment as indicated by the state plan. c. The facility policies regarding bed-hold periods. d. The facility per diem rate required to hold a bed	F 0626		

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F 0626 SS=D	<p>Continued from page 44</p> <p>(for a non-Medicaid residents), or to hold a bed beyond the state bed hold period (for Medicaid residents) and</p> <p>e. The return policy.</p> <p>The resident will be permitted to return to an available bed in the location of the facility that he or she previously resided. If there is not an available bed in that part, the resident will be given the option to take an available bed in another distinct part of the facility and return to the previous distinct part when a bed becomes available.</p> <p>Review of the clinical record indicates resident R50 was admitted to the facility on 10/28/21.</p> <p>Review of Resident R50's MDS dated 11/5/24, indicated the diagnosis of anemia (low iron in the blood), hypertension (high blood pressure), and quadriplegia (paralysis that affects all limbs and body parts from the neck down).</p> <p>Review of Health Status Note dated 1/21/25, at 8:47 p.m. indicates Resident is febrile (high</p>	F 0626		

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F 0626 SS=D	Continued from page 45 temperature), blood pressure low, heart rate elevated, I did call physician (on-call) reviewed Resident R50's clinical stats, and he agrees he needs to be sent out. Review of Health Status Note dated 1/21/25, at 9:01 p.m. indicates call to 911 to pick Resident R50 up and called to his mother, updated her on clinical status and the plan to send him out, she requested his board, charger and board stand go with him. Review of Social Service progress note dated 1/22/25, at 1:08 p.m. indicate social worker (SW) contacted Resident's mother to inform her that we will not be able to take Resident back a resident at this facility because we can no longer meet his needs. SW stated if she had any further questions or to inquire where he would be going, she could reach out to SW at the hospital. The mother responded with, "You got to be kidding me". Mother stated did not want facility to give away his stuff and she would be in to pick it up. SW stated that facility would not give his belongings away and would pack it up for	F 0626		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395845	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/24/2025	
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F 0626 SS=D	<p>Continued from page 46</p> <p>her. Mother stated she did not want facility to touch his belongings. SW stated that respiratory was already willing to assist with packing his belongings. The phone then went silent. Mother hung up on SW.</p> <p>During an interview completed on 1/23/25, at 11:57 a.m. upon asking Social Service Director Employee E2 why Resident R50 is not being permitted to return to the facility she replied, "because Resident R50 is refusing all medications, all tube feedings, all care is being refused, we can't care for him".</p> <p>During an interview completed on 1/23/24, at 12:40 p.m. upon asking the Director of Nursing why Resident R50 is not being permitted to return to the facility she replied, "cause his mom wants to continue giving things by mouth and he wants things by mouth, resident is an aspiration risk, and he is choosing to go against physician orders".</p> <p>During an interview completed on 1/24/25, at 9:00 a.m. the Nursing Home Administrator confirmed that Resident R50 will not be permitted to return to</p>	F 0626		

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F 0626 SS=D	Continued from page 47 the facility and that the facility failed to permit one of three residents who transferred to the hospital with the expectation of returning to the facility, return to the facility in a timely manner. (Resident R50) 28 PA. Code 201.14(a)(b) Responsibility of licensee 28 PA. Code 201.29(c.3) (4) Resident rights 28 PA. Code 211.12(d)(1) Nursing services	F 0626		
F 0657 SS=D		F 0657		

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F 0657 SS=D	Continued from page 48 483.21(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	Resident R1's care plan has been updated to include focused nutritional interventions. No negative outcomes were identified as a result of the missing care plan. Resident R50 will not be returning to the facility. The care plan has been closed. Resident R115 was discharged from the facility and had no negative outcomes as a result of the CarePlan not being updated. All resident Care Plans will be reviewed for accuracy. The DON or designee will educate all licensed nursing staff, social services, dietician, and MDS coordinators on the requirements of updating the comprehensive care plans. The DON or designee will audit five resident care plans weekly x8 to ensure updates are completed as needed. Results will be reviewed through QAPI for further recommendation.	Completion Date: 03/13/2025 Status: APPROVED Date: 02/24/2025

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F 0657 SS=D	Continued from page 49 Based on review of facility policy, clinical records, and staff interview, it was determined the facility failed to update a care plan for three of ten residents (Residents R1, R50, and R115) to accurately reflect the current status of the resident and care needs. Findings include: Review of the facility policy "Care Plans, Comprehensive Person-Centered" dated August 2024, indicated the facility must develop a comprehensive Person-Centered Care Plan for each resident that includes measurable objectives and timeframes and describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. Care plans are revised as information about the residents and residents' condition change. The interdisciplinary team reviews and updated the care plan: a. when there has been a significant change in resident's condition; b. when the desired outcome is not met:	F 0657		

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F 0657 SS=D	<p>Continued from page 50</p> <p>c. when the resident has been readmitted to the facility from a hospital stay; and d. at least quarterly, in conjunction with the required quarterly MDS assessment.</p> <p>Review of Resident R1's clinical record indicated the resident was admitted to the facility on 8/19/24.</p> <p>Review of Resident R1's Minimum Data Set (MDS - a periodic assessment of care needs) dated 11/6/24, indicated diagnoses of peripheral vascular disease (progressive disorder that causes narrowing or blocking of the blood vessels outside of the heart), heart failure, and dependance on renal dialysis (blood purifying treatment given when kidney function is not optimal). MDS section K0520 is coded for therapeutic and mechanically altered diet while a resident; MDS section M0300 is coded a "1" for number of stage 3 pressure ulcers; and MDS section O0110 is coded for dialysis while a resident.</p> <p>Review of Resident R1's Nutrition/Dietary note</p>	F 0657		

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F 0657 SS=D	<p>Continued from page 51</p> <p>dated 1/23/25, at 9:52 a.m., indicated that resident has chronic stage IV (pressure ulcer staging which extends below the subcutaneous fat into deep tissue, including muscle, tendon, and ligaments) left antecubital fossa, requires a therapeutic diet, and ongoing communication with dialysis dietitian.</p> <p>Review of Resident R1's current "potential for malnutrition" plan of care, initiated 8/26/24, updated 11/19/24, failed to identify focused nutritional problems, goals, and interventions specific to chronic pressure ulcer, therapeutic diet, and dialysis.</p> <p>During an interview on 1/24/25, at 9:00 a.m., Registered Dietitian (RD) Employee E12 confirmed that Resident R1's care plan failed to be updated and identify focused nutritional problems, goals, and interventions specific to resident's nutritional current plan of care.</p> <p>Review of the clinical record indicates resident R50 was admitted to the facility on 10/28/21.</p>	F 0657		

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F 0657 SS=D	Continued from page 52 Review of Resident R50's MDS dated 11/5/24, indicated the diagnosis of anemia (low iron in the blood), hypertension (high blood pressure) and quadriplegia (paralysis that affects all limbs and body parts from the neck down). Review of nursing progress note dated 1/9/25, indicates "resident continues to refuse feedings this am". Review of nursing progress notes date 1/11/25 indicates "resident vehemently refused his dinner feeding and flush". Review of Resident R50's MAR for January 2025, indicated the following dates marked with the number 2, indicating refused for tube feedings: 1/1/25, at 8:00 a.m., 1/4/25, at 8:00 a.m., 1/5/25, at 8:00 a.m., 1/7/25, at 8:00 a.m., 1/8/25, at 5:00 p.m., and 9:00 p.m., 1/10/25, at 9:00 p.m., 1/11/25, at 9:00 p.m., 1/12/25, at 5:00 p.m., 1/14/25, at 8:00 a.m., and 5:00 pm., 1/16/25, at 9:00 p.m., 1/18/25, at 4:00 p.m., 1/19/24 at 8:00	F 0657		

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F 0657 SS=D	Continued from page 53 a.m. Review of Resident R50's care plan on 1/22/25, at 9:47 a.m. did not include interventions for Resident R50's refusal of tube feedings. During an interview completed on 1/24/25, at 9:00 a.m. the Nursing Home Administrator confirmed Resident R50's care plan did not include interventions for refusal of tube feedings. Review of the clinical record indicated Resident R115 was admitted to the facility on 10/24/24, with the diagnoses of renal insufficiency (condition where the kidneys lose the ability to remove waste and balance fluids), atrial fibrillation (irregular heart rhythm), and heart failure (heart doesn't pump blood as well as it should). Review of physician order dated 10/24/24, indicated change valved PICC (peripherally inserted central catheter - a thin tube placed in a large vein near the heart to deliver fluids, blood and	F 0657		

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F 0657 SS=D	Continued from page 54 medications) to deliver needless connector and transparent dressing 24 hours after insertion, or on admission, and weekly. Document upper arm circumference (the distance around the widest part of a round object) in centimeters (cm) and external catheter length in cm with each dressing change. Compare to previous measurements. Notify physician if the length has changed since the last measurement. Review of Resident R115's progress notes dated, 10/26/24, at 8:35 p.m. indicated resident refused his bedtime medication pass. Review of Resident R115's progress notes dated 10/27/24, at 1:13 a.m. indicated resident was pushing all the buttons on his intravenous pump (IV pump used to deliver infusions). Review of Resident R115's current care plan on 1/24/25, at 9:50 a.m. failed to include a problem, goal, or interventions for the PICC line, and failed to address resident's refusal of medications and care.	F 0657		

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F 0657 SS=D	Continued from page 55 Interview on 1/24/25, at 10:00 a.m. the Nursing Home Administrator confirmed R115's care plan lacked care of the PICC line, and refusal of medications and care. During an interview on 1/24/25, at 3:15 p.m., the Director of Nursing (DON) confirmed that the facility failed to update a care plan for three of ten residents (Residents R1, R50, and R115) to accurately reflect the current status of the resident and care needs. 28 Pa. Code: 211.12(d)(1)(5) Nursing services.	F 0657		
F 0684 SS=E		F 0684		

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F 0684 SS=E	Continued from page 56 483.25 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	Facility is unable to retroactively correct concern of lack of assessment of the residents for signs/symptoms of hypoglycemia or hyperglycemia. Director of Nursing and/or designee reviewed the blood glucoses with the attending physicians for all listed residents. Resident R67 Remains at the facility. Resident R67 was seen on 1/16/2025 and no negative outcome was identified. Resident R115 has been discharged as planned with no negative outcomes. All residents receiving blood sugars will have a retroactive 14-day review of blood sugars with notifications to physicians as necessary. R67's PT/INR results will be communicated to the LVAD team as ordered and reviewed with attending physician when new orders are received. A one-week retroactive review of all new admissions will be audited to ensure that orders have been transcribed correctly. The Director of Nursing or designee will educate licensed nurses on facility's policies for assessing for change in	Completion Date: 03/13/2025 Status: APPROVED Date: 02/24/2025

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F 0684 SS=E	Continued from page 57	F 0684	condition, physician notifications, hypoglycemia, and Medication and treatment orders. The Director of Nursing or designee will audit CBG monitoring summaries for residents who require CBG testing and ensure resident assessment and physician notifications are made when an abnormal CBG is recorded. These audits will be completed on all CBG residents daily x 3 days, then a random five CBG residents three times weekly x 2 weeks and then weekly for 2 months. All new admissions will be audited to ensure orders are transcribed correctly three times weekly x 3 months. All notifications of PT/INR's for LVAD team notifications will be audited three times weekly for two weeks, then weekly for two months. All results to be reviewed through QAPI for further recommendation.	

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F 0684 SS=E	Continued from page 58 Based on review of facility policy, clinical records, and staff interview it was determined that the facility failed to notify a physician of abnormal glucose readings and lab results as per order for three of six residents (Residents R67, R77, and R167) and failed to follow a physician order for two of five residents (Resdient R67, and Resident R115). Findings include: Review of the facility policy "Medication and Treatment Orders" dated August 2024, indicated orders for medications and treatments will be consistent with principles of safe and effective order writing. Review of facility policy "Management of Hypoglycemia" dated 8/24, indicated the purpose is to provide guidelines for managing hypoglycemia (low blood sugar) to insulin therapy or therapy with oral hypoglycemic agents in the diabetic resident. Symptoms of hypoglycemia (low blood sugar level) may include:	F 0684		

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F 0684 SS=E	Continued from page 59 - Weakness, dizziness, or fainting - Restlessness and/or muscle twitching - Increased heart rat - Pale, cool, moist skin - Excessive sweating - Irritability or bizarre changes in behavior - Blurred or impaired vision - Headaches - Numbness of the tongue and the lips/thick speech More severe symptoms include: - Stupor (a state of near-unconsciousness), unconsciousness and/or convulsions (sudden uncontrolled electrical disturbances in the brain which can cause changes in behavior, movements, feelings, and consciousness) - Coma (a state of prolonged unconsciousness where the patient cannot respond to external stimuli). Classification of hypoglycemia:	F 0684		

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F 0684 SS=E	Continued from page 60 - Level 1 hypoglycemia: blood glucose less than 70 mg/dL (milligrams per deciliter) but greater than 54 mg/dL; - Level 2 hypoglycemia: blood glucose is less than 54 mg/dL and; - Level 3 hypoglycemia: altered mental status and/or physician status requiring assistance for treatment of hypoglycemia Treatments for hypoglycemia levels include: - For Level 1 hypoglycemia, give the resident an oral form of rapidly absorbed glucose (15-20 grams), notify the provider immediately, remain with the resident, and recheck blood glucose in 15 minutes. - For Level 2 hypoglycemia, administer glucagon (intranasal [via the nose], intramuscular [into a muscle], or as provided), notify the provider immediately, remain with the resident, place resident in a comfortable and safe place, monitor vital signs, and recheck blood glucose in 15 minutes. - For Level 3 hypoglycemia and is unresponsive, call 911, administer glucagon (a medication used to	F 0684		

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F 0684 SS=E	Continued from page 61 increase blood sugar levels) (intranasal, intramuscular, or as provided), notify the provider immediately, remain with the resident, place the resident in a safe place, and monitor vital signs. Review of the clinical record indicated Resident R67 was admitted on 12/18/24. Review of the MDS (minimum data set a periodic assessment of resident needs) dated 12/24/24, atrial fibrillation (a-fib- irregular heart rhythm), heart failure (heart doesn't pump blood as well as it should) and CAD- coronary artery disease (narrowing or blockage of the arteries - a heart disease). Review of Resident R67 current physician record indicated to check residents blood sugar level. If blood sugar is less than 70 call MD, If blood sugar level is over 400 call MD. Review of clinical record MAR (medication administration record), blood sugar indicated the	F 0684		

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F 0684 SS=E	Continued from page 62 following: 1/6/25 - 403 at 5:00 p.m. physician not made aware. 1/11/25 - 429 at 5:00 p.m. physician not made aware. Review of Resident R67 clinical record progress notes indicated the following: 9/29/24: Called by nurse for PT/INR (lab result) results. INR supratherapeutic at 4.1. Advised nurse that Resident R67 with LVAD (left ventricle assist device) and follows with LVAD clinic who manages his Coumadin (blood thinner). Per order in the chart, "every shift Call/fax PT/INR results to Hospital Anticoagulation Team. Nurse to call LVAD team for further direction. Review of Resident R67 clinical record failed to include notification to LVAD team of PT/INR results. During an interview on 1/24/25, at 10:55 .m.	F 0684		

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F 0684 SS=E	<p>Continued from page 63</p> <p>Director of Nursing (DON) confirmed that the facility failed to notify the physician for Resident R67 high blood sugar level as ordered by the physician, and failed to notify the LVAD team of the high PT/INR and the facility failed to meet Resident R67 care needs.</p> <p>Review of the clinical record indicated Resident R77 was admitted to the facility on 7/16/24.</p> <p>Review of Resident R77's Minimum Data Set (MDS - a periodic assessment of care needs) dated 12/2/24, indicated diagnoses of high blood pressure, diabetes (a metabolic disorder in which the body has high sugar levels for prolonged periods of time), and cancer (abnormal cells that can cause tumors in healthy tissue).</p> <p>Review of Resident R77's current physician orders indicated to check residents blood sugar level. If blood sugar is less than 70, repeat in 15 minutes and notify the physician immediately. Glucose (sugar gel) oral gel, give 15 grams orally as needed for</p>	F 0684		

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F 0684 SS=E	Continued from page 64 diabetes. Recheck blood sugar in 15 minutes. Glucose oral gel, give 30 grams (two tubes) as needed, recheck blood sugar in 15 minutes. GlucGen Injection one mg (milligram) intramuscularly as needed. The medications above failed to have set parameters as to when to give the medication during a hypoglycemic incident. Review of Resident R77's blood sugar readings were the following: 12/4/24 - 68 at 11:57 a.m. Physician not made aware. No interventions documented. 12/8/24 - 59 at 5:39 p.m. Physician not made aware. No interventions documented. 12/13/24 - 55 at 4:50 p.m. Physician not made aware. No interventions documented. 12/15/24 - 66 at 12:02 p.m. Physician not made aware. No interventions documented. 12/26/24 - 67 at 6:17 p.m. Physician not made aware. No interventions documented. 1/6/25 - 66 at 12:12 p.m. No interventions documented.	F 0684		

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F 0684 SS=E	<p>Continued from page 65</p> <p>1/10/25 - 38 at 5:02 p.m. No interventions documented.</p> <p>1/15/25 - 62 at 6:02 a.m. No interventions documented.</p> <p>1/22/15 - 68 at 11:57 a.m. No interventions documented.</p> <p>During an interview on 1/23/25, at 2:52 p.m. Director of Nursing stated, "I don't see any parameters on the medications, I don't see that anyone notified the doctor, and no documentation to follow up on the low blood sugars".</p> <p>Review of the clinical record indicated Resident R115 was admitted to the facility on 10/24/24, with the diagnoses of renal insufficiency (condition where the kidneys lose the ability to remove waste and balance fluids), atrial fibrillation (irregular heart rhythm), and heart failure (heart doesn't pump blood as well as it should).</p> <p>Review of Resident R115's admission orders dated 10/24/24, indicated Bumex (a medication that</p>	F 0684		

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F 0684 SS=E	Continued from page 66 increases urine production, helping the body get rid of excess fluid and salt) 2 mg (milligrams) give one tablet daily for congestive heart failure. Review of Resident R115's hospital discharge "Final Medication List" dated 10/24/24, indicated bumex 2mg tablet give two tablets daily. Review of Physician Employee E15's progress noted dated 10/27/24, indicated "Questioned about bumex it was 2mg. Resident stated it was supposed to be 4mg. Checked records and resident is to get 4mg daily. Recommended nursing to correct". Interview on 1/24/25, at 1:24 p.m. the Nursing Home Administrator confirmed the bumex was transcribed incorrectly on admission. Interview on 1/24/25, at 3:00 p.m. the Director of Nursing confirmed the facility failed to notify a physician of abnormal glucose readings and lab results as per order for three of six residents (Residents R67, R77, and R167) and failed to	F 0684		

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F 0684 SS=E	Continued from page 67 follow a physician order for one of five residents (Resident R115). 28 Pa. Code: 201.14(a) Responsibility of licensee. 28 Pa. Code: 201.18(a)(b)(3) Management. 28 Pa. Code: 211.12 (d)(1)(3)(5) Nursing services.	F 0684		
F 0689 SS=D		F 0689		

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F 0689 SS=D	Continued from page 68 483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2) Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by:	F 0689	Resident R42 remains at the facility and suffered no negative outcomes as a result of his elopements. Resident R114 did not return to the facility and the facility was not notified of any negative outcomes as a result of leaving via UBER ride service. Resident R50 was transferred to the hospital for unrelated health issues and will not be returning to the facility. The facility has installed magnetic alarms at the facility front entrance to alert staff of anyone opening the emergency release when the doors are locked, or a receptionist is not present. The courtyard doors are now to be locked at all times for temps below 50 degrees unless a staff member is present for supervision of any cognitively impaired residents. The facility will install wander guard systems on the courtyard doors. All staff will be educated by the NHA or designee on elopement and required supervision, and courtyard use. All Direct care staff will be educated in following prescribed diet orders.	Completion Date: 03/13/2025 Status: APPROVED Date: 02/24/2025

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F 0689 SS=D	Continued from page 69	F 0689	The DON or designee will audit all incidents for elopements and failing to follow prescribed physician orders. All NPO residents will be audited once a week to ensure that physician orders are followed. Courtyard doors will be audited daily to ensure they always remain locked while awaiting wander guard installation. Results will be reviewed through QAPI for further recommendation.	

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F 0689 SS=D	Continued from page 70 Based on clinical and facility record review, facility provided documents and staff interviews, it was determined that the facility failed to provide adequate supervision for two residents resulting in elopement (resident exited to an unsupervised or unauthorized location without staff's knowledge) for two of two residents (Residents R42, and R114), and failed to follow a prescribed diet order for one of three residents (Resident R50). Findings include: Review of the facility policy "Wandering and Elopements" dated August 2024, indicated the facility will identify residents who are at risk of unsafe wandering and strive to prevent harm. Review of the facility policy "Assistance with meals" dated August 2024, indicates residents shall receive assistance with meals in a manner that meets the individual need of each resident. Residents with feeding tubes, nursing staff will provide feedings to tube feed residents.	F 0689		

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F 0689 SS=D	Continued from page 71 Review of the facility policy "Therapeutic Diets" dated August 2024, indicated therapeutic diets are prescribed by the attending physician to support a residents treatment and plan of care. Review of the clinical record revealed that Resident R42 was admitted to the facility on 8/1/23. Review of Resident R42's MDS (Minimum Data Set, periodic assessment of resident care needs) dated 12/6/24, indicated diagnoses of high blood pressure, dementia (a group of symptoms that affects memory, thinking and interferes with daily life), and Parkinson's disease (neuromuscular disorder causing tremors and difficulty walking). Review of Resident R42's MDS assessment section C0200 Brief Interview for Mental Status ("BIMS", a screening test that aides in detecting cognitive impairment). The BIMS total score suggests the following distributions: 13-15: cognitively intact, 8-12: moderately impaired, 0-7: severe impairment. Resident R42's BIMS score was a "3" indicating	F 0689		

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F 0689 SS=D	Continued from page 72 Resident R42 was severely impaired. Review of Resident R42's care plan dated 8/14/24, at 9:02 a.m. revealed that outside facility patio needs - supervised. During review of Resident R42's clinical record indicated a nurse's progress note on 12/21/24, at 1:42 p.m. that stated "while this nurse was at lunch resident went outside in the snow. Brought back in by Registered Nurse (RN). Asked concierge to lock both doors in the dining room for safety. She checked and locked both doors, but resident went out dining room door due to it not being securely locked. This nurse and RN was bringing resident back in. He was swinging, scratching and trying to punch staff. Got male nurse assistant to help and was brought back to his room, notified residents father". The facility failed to document an assessment upon returning resident into the facility and failed to notify the physician. During review of Resident R42's clinical record	F 0689		

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F 0689 SS=D	<p>Continued from page 73</p> <p>indicated a nurse's progress note on 12/23/24, at 2:19 p.m. that stated "resident outside in the snow. Witnessed by social services who brought him inside. Notified resident's father". The facility failed to document an assessment upon returning resident into the facility and failed to notify the physician.</p> <p>During an interview on 1/22/25, at 2:05 p.m. the Director of Nursing stated "We did not treat him going outside to the patio as an elopement because they have the right to go into the courtyard. We encourage them. The Nursing Home Administrator (NHA) and I saw him go outside". The facility failed to provide documentation of Resident R42 being seen going outside by himself, unsupervised.</p> <p>During an interview on 1/22/25, at 2:31 p.m. Licensed Practical Nurse (LPN) Employee E8 stated, "He was not wearing a coat on both days, he was not cold, and I did do an assessment but didn't document it. He likes to be outside and stated he wanted to stay out in the snow".</p>	F 0689		

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F 0689 SS=D	Continued from page 74 During an interview on 1/23/25, at 10:13 a.m. NHA confirmed that the facility failed to recognize the above incidents as elopement and will notify the appropriate agency of the events. Review of the clinical record indicates resident R50 was admitted to the facility on 10/28/21. Review of Resident R50's MDS dated 11/5/24, indicated the diagnosis of anemia (low iron in the blood), hypertension (high blood pressure) and quadriplegia (paralysis that affects all limbs and body parts from the neck down). Review of Resident R50's physician orders dated 8/1/24, indicated Diet nothing by mouth (NPO). Review of Resident R50's physician orders dated 10/29/24, indicated NPO diet. Review of progress note dated 1/9/25, indicates Resident R50 has been followed by speech at facility throughout stay. Speech recommendations	F 0689		

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F 0689 SS=D	<p>Continued from page 75</p> <p>are that Resident R50 remains NPO for severe aspiration risk. Further review of progress note indicates that the resident has been consuming large amounts of fluids.</p> <p>Review of physician progress note dated 1/10/25, indicates staff has expressed aspiration concerns. Resident has a documented history of aspiration and requires enteral feeds. Made aware today that the resident has been consuming significant quantities of fluids and soups provided by mother, including weekly supplies of mountain dew and power aid.</p> <p>Review of progress note dated 1/10/25, this Director of Nursing (DON) discussed oral fluid intake by resident with attending physician. Physician has agreed to not allow staff to administer oral fluids due to safety risk at this time.</p> <p>Review of Resident R50's Kardex dated 1/13/25, interventions included aspiration precautions. Eating/Nutrition indicated aspiration precautions, g-tube, NPO.</p>	F 0689		

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F 0689 SS=D	Continued from page 76 During an interview on 1/23/25, at 12:40 p.m. the DON confirmed that Resident R50 was given liquids by staff members despite having orders for a NPO diet and the facility failed to follow a prescribed diet order for one of three residents (Resident R50). Review of the Admission Record indicated Resident R114 was admitted to the facility on 11/4/24, with the diagnoses of alcoholic cirrhosis (A late stage of liver disease. Occurs when scar tissue replaces health liver tissue due to long term alcohol consumption), anxiety disorder (intense, excessive, and persistent worry and fear about everyday situations), and chronic obstructive pulmonary disease (COPD- a group of diseases that block airflow and make it hard to breathe). Review of Resident R114's progress noted dated 11/17/24, at 4:09 p.m. the Director of Nursing received notification that resident wanted to be discharged against medical advice (AMA).	F 0689		

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F 0689 SS=D	<p>Continued from page 77</p> <p>Discussions regarding inability to set up home care services/outpatient appointments, and not receiving some or all of his medications if he was to leave AMA. Resident R114 and his family member were willing to remain at the facility until physician and care team were available to assess discharge needs on Monday morning.</p> <p>Review of Resident R114's progress notes dated 1/18/24, at 4:00 a.m. indicated at around 1:00 a.m. when staff went to check in on resident, he was not in his room or bathroom. After a thorough search staff realized he was no longer in his room. Attempts to call resident's phone and sister's phone without success. Resident had previously expressed interest in leaving the facility.</p> <p>Review of Resident R114's progress note dated 11/18/24, at 8:30 a.m. indicated resident left the facility in the middle of the night at 11:12 p.m. on 11/17/24, via Uber (ride service). Resident left AMA.</p>	F 0689		

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F 0689 SS=D	<p>Continued from page 78</p> <p>Review of Resident R114's discharge summary note dated 11/18/24, at 10:13 a.m. indicated was just notified that resident eloped and subsequently will be considered AMA.</p> <p>Interview with the Nursing Home Administrator on 1/23/25, at 3:30 p.m. indicated the facility was not aware Resident R114 was not in the facility, and that the facility did not recognize this as an elopement and called it an AMA discharge.</p> <p>Interview on 1/24/25, at 3:15 p.m. the Director of Nursing confirmed the facility failed to provide adequate supervision for two residents resulting in elopement for two of two residents (Residents R42, and R114), and failed to follow a prescribed diet order for one of three residents (Resident R50).</p> <p>28 Pa. Code: 201.14(a) Responsibility of licensee. 28 Pa. Code: 201.18(a)(b)(3) Management. 28 Pa. Code: 211.12 (d)(1)(3)(5) Nursing services.</p>	F 0689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395845	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/24/2025
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NAME OF PROVIDER OR SUPPLIER: CRANBERRY PLACE STATE LICENSE NUMBER: 381602	STREET ADDRESS, CITY, STATE, ZIP CODE: 5 ST. FRANCIS WAY CRANBERRY TOWNSHIP, PA 16066
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F 0689 SS=D	Continued from page 79	F 0689		
F 0690 SS=D		F 0690		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395845	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/24/2025
NAME OF PROVIDER OR SUPPLIER: CRANBERRY PLACE STATE LICENSE NUMBER: 381602		STREET ADDRESS, CITY, STATE, ZIP CODE: 5 ST. FRANCIS WAY CRANBERRY TOWNSHIP, PA 16066		
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F 0690 SS=D	Continued from page 80 483.25(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	Residents R3 and R62 had dignity bags applied at the time of survey. Resident R317's orders and care plan have been updated to include size and fluid amount needed for the catheter balloon. A whole house sweep has been conducted to ensure all catheters have dignity bag covers. All catheter orders and care plans will be reviewed to ensure they are complete. All licensed nurses will be educated by the DON or designee on physician orders for catheters, care plan requirements and resident dignity bags. The DON or designee will audit all catheter bags for dignity covers, orders for catheters to include size and fluid amount needed for the catheter balloon, and care plans to include the size of catheter or the amount of fluid needed for the catheter balloon. Audits will be completed weekly x 8 weeks. All results to be reviewed through QAPI for further recommendation.	Completion Date: 03/13/2025 Status: APPROVED Date: 02/24/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395845	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/24/2025
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F 0690 SS=D	Continued from page 81 This REQUIREMENT is not met as evidenced by:	F 0690		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395845	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/24/2025
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F 0690 SS=D	Continued from page 82 Based on review facility policies, observations, clinical records, and staff interviews it was determined that the facility failed to make certain that appropriate treatments and services were provided for the use of a urinary catheter as required for three of six residents (Resident R3, R62 and R317) and failed to update a care plan for one of three residents (R317) to accurately reflect the current status of the resident and care needs. Findings include: Review of facility policy "Dignity" dated 8/24, indicated that each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem. Review of Resident R3's clinical record indicated the resident was admitted to the facility on 3/16/23. Review of Resident R3's MDS (Minimum Data Set, periodic assessment of resident care needs) dated	F 0690		

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F 0690 SS=D	<p>Continued from page 83</p> <p>12/8/24, indicated diagnoses of high blood pressure, dementia (a group of symptoms that affects memory, thinking and interferes with daily life), and multiple sclerosis (a disease that affects central nervous system).</p> <p>Review of the clinical record revealed that Resident R3 had a physician's order dated 10/4/24, for suprapubic catheter for neurogenic bladder (urinary bladder problem due to disease or injury of central nervous system or nerves in the control of urination). Apply dignity bag. Check placement every shift.</p> <p>During an observation on 1/21/25, at 10:55 a.m. Resident R3 was observed lying in bed with her urinary catheter bag hanging from bed frame without a privacy-dignity bag.</p> <p>During an interview on 1/21/25, at 11:02 a.m. Registered Nurse Employee E4 confirmed that Resident R3 did not have a privacy-dignity bag on her catheter drainage bag.</p>	F 0690		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395845	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/24/2025
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F 0690 SS=D	Continued from page 84 Review of Resident R62's clinical record indicated the resident was admitted to the facility on 3/29/24. Review of Resident 62's MDS dated 12/25/24, indicates the diagnosis of anemia (low iron in the blood), neurogenic bladder (causes a loss of control of urination) and quadriplegia (paralysis that affects all limbs and body parts from the neck down). Review of Resident R62's physician orders dated 10/2/24, indicates condom catheter (external noninvasive urinary catheter that fits like a condom over the penis) every day, apply dignity bag, check for placement each shift. During an observation on 1/21/25, at 10:15 a.m. Resident R62 was in bed his catheter bag was attached to the bed frame facing the door and failed to have a privacy- dignity cover. During an interview on 1/21/25, at 10:17 a.m. Registered Nurse (RN) Employee E10 confirmed Resident R62's catheter bag did not have a privacy-	F 0690		

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F 0690 SS=D	Continued from page 85 dignity cover. A review of Resident R317's clinical record indicate an admission date of 1/16/25, with the diagnosis of aphasia (language disorder that affects speech), hyperlipidemia (high fat in the blood) and respiratory failure with hypoxia (low levels of oxygen in the body tissues). Review of Resident R317's physician orders dated 1/21/25, indicate monitor indwelling catheter document size and urinary output size 18 french (fr) the order failed to include the fluid amount needed for the catheter balloon (holds the catheter in place in the bladder) securement. Review of Resident R317's care plan dated 1/21/25, did not include the size of catheter or the amount of fluid needed for the catheter balloon. During an interview completed on 1/23/24, at 11:40 a.m. RN Employee E7 confirmed the catheter order failed to include the amount of fluid needed for the	F 0690		

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F 0690 SS=D	Continued from page 86 balloon and the care plan failed to include the size of the catheter or the amount of fluid needed for balloon. During an interview on 1/21/25, at 3:00 p.m. the Director of Nursing confirmed that the facility failed to make certain that appropriate treatments and services were provided for the use of a urinary catheter as required for three of six residents (Resident R3, R62, and R317). 28 Pa Code: 201.14 (a) Responsibility of licensee. 28 Pa code: 211.10 (c)(d) Resident care policies. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services.	F 0690		
F 0693 SS=E		F 0693		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395845	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/24/2025
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F 0693 SS=E	Continued from page 87 483.25(g)(4)(5) Tube Feeding Mgmt/Restore Eating Skills §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by:	F 0693	Residents R0, R52, R70 and R103 tube feeds/water flushes/tubing were dated at the time of survey. A whole house sweep was conducted to ensure all tube feeds/water flush/tubing was dated. The DON or designee will educate all Licensed Nurses on labeling and dating all components of the tube feed system. The DON or designee will audit all tube feeds daily x3, and five tube feeds weekly for proper labeling and dating of tube feed systems. All results to be reviewed through QAPI for further recommendation.	Completion Date: 03/13/2025 Status: APPROVED Date: 02/24/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395845	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/24/2025	
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F 0693 SS=E	Continued from page 88 Based on review of facility policy, clinical record review, observation, and staff interview, it was determined that the facility failed to ensure that residents with an enteral feeding tube (a tube inserted in the stomach through the abdomen) received appropriate treatment and services to prevent potential complications for four of five residents (Residents R40, R53, R70, and R103). Findings include: Review of facility policy "Enteral Tube Feeding via Continuous Pump" dated 8/24, indicated the purpose of this procedure is to provide a guideline for the use of a pump for enteral feedings. Check the enteral nutrition label against the order before administration. Check the following information: - Residents name, ID, and room number - Type of formula - Date and time formula was prepared - Rate of administration	F 0693		

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F 0693 SS=E	<p>Continued from page 89</p> <p>Review of Resident R40's clinical record indicated the resident was admitted to the facility on 6/4/24.</p> <p>Review of Resident R40's Minimum Data Set (MDS - a periodic assessment of care needs) dated 1/1/25, indicated diagnoses of difficulty walking, cancer (a disease that occurs when cells grown and divide uncontrollably, forming tumors that can invade and destroy healthy tissue), and hyperlipidemia (high levels of fat in the blood). MDS section K0520 is coded feeding tube while a resident.</p> <p>Review of current physician order indicated Jevity 1.5 (a type of feeding that will supply a person with nutrients and minerals) to be administered continual over 20 hours. Flush tube with 125 ml (milliliters) of warm water every four hours. Change feeding bag and tubing daily.</p> <p>During a tour of unit on 1/21/25, at 10:45 a.m. Resident R40's enteral feeding was observed hanging at bedside with the date 1/21/25, written on</p>	F 0693		

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F 0693 SS=E	<p>Continued from page 90</p> <p>the bag. Water flush bag failed to have a date written on the bag.</p> <p>During an interview on 1/21/25, at 11:02 a.m. Registered Nurse Employee E4 confirmed she did not see a date on the water flush bag and wrote the date on it.</p> <p>Review of Resident R53's clinical record indicated he was admitted to the facility on 3/13/24.</p> <p>Review of Resident R53's Minimum Data Set (MDS - a periodic assessment of care needs) dated 12/20/24, indicated diagnoses of quadriplegia (a symptom of paralysis that effects all limbs and body from the neck down), chronic pulmonary disease, and anxiety disorder. MDS section K0520 is coded feeding tube while a resident.</p> <p>Review of current physician orders indicated Kate Farms Peptide 1.5, 256 cc (cubic centimeter) intermittent feeding via pump QID (four times per day) to run over 2 hours each time; flush tube with</p>	F 0693		

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F 0693 SS=E	<p>Continued from page 91</p> <p>150 ml (milliliters) every four hours for hydration.</p> <p>During a tour of unit on 1/21/25, at 12:45 p.m., Resident R53's enteral feeding was observed hanging at bedside with the date 1/21/25, written on the bag. Water flush bag failed to have a date written on the bag.</p> <p>During an interview on 1/21/25, at 12:51 p.m., Registered Nurse Employee E5 confirmed she did not see a date on the water flush bag.</p> <p>Review of Resident R70's clinical record indicated the resident was admitted to the facility on 6/26/23.</p> <p>Review of Resident R70's MDS dated 11/9/24, indicated diagnoses of cancer, depression, and peripheral vascular disease (PVD, circulatory condition in which narrowed blood vessels reduce blood flow to the limbs). MDS section K0520 is coded feeding tube while a resident.</p> <p>Review of current physician order indicated</p>	F 0693		

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F 0693 SS=E	<p>Continued from page 92</p> <p>Osmolite 1.5 (a type of feeding that will supply a person with nutrients and minerals) to be administered continual over 20 hours. Flush tube with 200 ml of warm water every six hours. Change feeding bag and tubing every night shift.</p> <p>During a tour of unit on 1/21/25, at 10:55 a.m. Resident R70's enteral feeding was observed hanging at bedside without a date written on the bag, and water flush bag failed to have a date written on the bag.</p> <p>During an interview on 1/21/25, at 11:07 a.m. Registered Nurse (RN) Employee E4 confirmed she did not see a date on the tube feed and water flush bag and wrote the date on it.</p> <p>A review of Resident R103's clinical record indicates an admission date of 11/29/24.</p> <p>A review of Resident R103's MDS dated 12/5/24 indicates the diagnosis of coronary artery disease (CAD- narrowing or blockage of arteries), heart</p>	F 0693		

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F 0693 SS=E	<p>Continued from page 93</p> <p>failure (heart doesn't pump the way it should), and hypertension (high blood pressure).</p> <p>A review of Resident R103's physician orders dated 1/15/25, indicates enteral feed order every evening and night shift Kate farms peptide 1.5 (plant-based formula) 75 milliliter (ml) per hour for six hours per day (on at 9:00 p.m. off at 3:00 a.m.).</p> <p>During an observation 01/21/25, at 9:48 a.m. Resident R103's formula bag and water flush bag were hanging at the bedside without a date written on the formula bag, the water flush bag also failed to be labeled with the date.</p> <p>During an interview completed on 1/21/25, at 9:53 a.m. RN Employee E7 confirmed Resident R103's formula bag and water flush bag were hanging at bedside without a date written on them as required.</p> <p>During an interview on 1/21/25, at 3:00 p.m. the Director of Nursing confirmed that the facility failed to ensure that residents with an enteral feeding tube</p>	F 0693		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395845	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/24/2025
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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 0693 SS=E	Continued from page 94 received appropriate treatment and services to prevent potential complications for four of five residents (Residents R40, R53, R70, and R130). 28 Pa. Code: 201.18(b)(1) Management. 28 Pa. Code: 211.10(c) Resident care policies. 28 Pa. Code: 211.12(d)(1) Nursing services.	F 0693		
F 0695 SS=E		F 0695		

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F 0695 SS=E	Continued from page 95 483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by:	F 0695	Resident R'2 orders were corrected to include an oxygen saturation percentage at the time of survey. All residents identified in the citation were checked and provided with new oxygen tubing, humidification bottles, nebulizers and bags for storage as required at the time of survey. A whole house audit was completed for all residents receiving respiratory care for dating, labeling and storage was completed on 1/21/25. The DON or designee with educate all licensed nursing and respiratory staff on the policy for respiratory therapy. The DON or designee will audit all respiratory care equipment for labeling, dating and storage daily x3 days, then 5 residents weekly x 8 weeks. All results to be reviewed through QAPI for further recommendation.	Completion Date: 03/13/2025 Status: APPROVED Date: 02/24/2025

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F 0695 SS=E	Continued from page 96 Based on review of facility policy, clinical records, observations and staff interviews, it was determined that the facility failed to provide appropriate respiratory care and maintain oxygen equipment for five of six residents (Residents R2, R70, R77, R103, and R317). Findings include: A review of the facility policy "Respiratory Therapy" last reviewed on 8/24, indicates to guide prevention of infection associated with respiratory therapy task and equipment, including ventilators, among residents and staff. Steps in the procedure include but not inclusive to: <ul style="list-style-type: none"> . Change the oxygen cannula and tubing every 7 days or as needed. . Wash filters from oxygen concentrators every 7 days with soap and water. Rinse and squeeze dry. . Store the circuit in plastic bag, marked with date and residents name, between uses. A review of Resident R2's clinical record indicate an	F 0695		

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F 0695 SS=E	Continued from page 97 admission date of 7/6/23. A review of R2's Minimum Data Set (MDS-periodic assessment of care needs) dated 11/7/24, indicate the diagnosis of anemia (low iron in the blood), hypertension (high blood pressure), and hypoxemia (low concentration of oxygen in the blood). A review of Resident R2's physician orders dated 7/31/24, indicate Oxygen (O2) - specify liters per minute (lpm) and delivery method in notes every shift. 4-6 lpm via nasal canula (NC) maintain respiratory comfort and failed to include the percentage of oxygen saturation parameter to maintain comfort. A review of Resident R2's physician orders dated 7/31/24, indicate titrate oxygen to maintain oxygen saturation as needed to maintain comfort, and failed to include the percentage of oxygen saturation parameter to maintain comfort.	F 0695		

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F 0695 SS=E	<p>Continued from page 98</p> <p>During an interview completed on 1/23/24, at 11:37 a.m. Registered Nurse (RN) Employee E7 confirmed the orders for Resident R2's oxygen did not contain the oxygen saturation level, just states comfort and stated "I just spoke to the hospice practitioner and received a new order to maintain a level of 92% (percent), I will put the order in".</p> <p>Review of Resident R70's clinical record indicated the resident was admitted to the facility on 6/26/23.</p> <p>Review of Resident R70's MDS dated 11/9/24, indicated diagnoses of depression, cancer (a disease that occurs when cells grow and divide uncontrollably, forming tumors that can invade and destroy healthy tissue), and peripheral vascular disease (PVD, circulatory condition in which narrowed blood vessels reduce blood flow to the limbs).</p> <p>Review of the clinical record revealed that Resident R70 had current physician order for oxygen and to change and date oxygen tubing every Tuesday night.</p>	F 0695		

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F 0695 SS=E	Continued from page 99 During an observation on 1/21/25, at 10:55 a.m. Resident R70 was observed sitting in his wheelchair with oxygen on per physician order and failed to have a date on his oxygen tubing. During an interview on 1/21/25, at 11:02 a.m. Registered Nurse (RN) Employee E4 confirmed that Resident R70's oxygen tubing was not dated. Review of Resident R77's clinical record indicated the resident was admitted to the facility on 12/6/23. Review of Resident R77's MDS dated 12/2/24, indicated diagnoses of high blood pressure, cancer, and diabetes (a metabolic disorder in which the body has high sugar levels for prolonged periods of time). Review of the clinical record revealed that Resident R77 had current physician orders for Ipratropium-Albuterol (medication inhaled to treat shortness of breath and wheezing) three times a day.	F 0695		

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F 0695 SS=E	Continued from page 100 During an observation on 1/21/25, at 10:58 a.m. Resident R77 was observed lying in bed with her nebulizer (machine used to administer medication) tubing and mask on her bedside dresser, unlabeled and not in a bag. During an interview on 1/21/25, at 11:02 a.m. RN Employee E4 stated, "I don't see a date on the tubing and its not in a bag" and confirmed the above findings. Review of Resident R103's clinical record indicates an admission date of 11/29/24. Review of Resident R103's MDS dated 12/5/24, indicates the diagnosis of coronary artery disease (CAD- narrowing or blockage of arteries), heart failure (heart doesn't pump the way it should), and hypertension (high blood pressure) A review of Resident R103's physician orders dated 11/29/24, indicates ipratropium albuterol solution	F 0695		

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F 0695 SS=E	Continued from page 101 0.5-2.5 (3) milligrams(mg) 3 milliliters (ml) 3 ml inhale orally every 4 hours as needed for shortness of breath or wheezing via nebulizer. During an observation 01/21/25, at 9:48 a.m. Resident R 103's nebulizer was sitting on top of dresser not stored in a bag. During an interview completed on 1/21/25, at 9:53 a.m. RN Employee E7 confirmed the nebulizer was not stored in a bag as required Review of Resident R317's clinical record indicate an admission date of 1/16/25, with the diagnosis of aphasia (language disorder that affects speech), hyperlipidemia (high fat in the blood), and respiratory failure with hypoxia (low levels of oxygen in the body tissues). Review of Resident R317's physician orders dated 1/16/25, indicate oxygen at 2 liters per minute (lpm) via nasal cannula (thin flexible tube used to deliver oxygen) every shift.	F 0695		

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F 0695 SS=E	<p>Continued from page 102</p> <p>During an observation on 1/21/25, at 10:01 a.m. Resident R317 was resting in his bed with his oxygen on. The oxygen tubing and humidifier bottle (prevents airways from becoming dry) failed to be labeled with a date.</p> <p>During an interview completed on 1/21/25 at 10:06 a.m. Licensed Practical Nurse (LPN) Employee E9 confirmed Resident R317's oxygen tubing and humidifier bottle failed to be labeled with a date.</p> <p>Interview with the Director of Nursing on 1/124/25, at 3:00 p.m. confirmed the facility failed to provide appropriate respiratory care and maintain oxygen equipment for five of six residents (Residents R2, R70, R77, R103, and R317).</p> <p>28 Pa. Code: 211.10(c)(d) Resident care policies. 28 Pa. Code: 211.12(d)(1)(2)(3)(5) Nursing services.</p>	F 0695		

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F 0695 SS=E	Continued from page 103	F 0695		
F 0698 SS=D	483.25(l) Dialysis §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by:	F 0698	Resident R1 remains in the facility and had no negative outcomes from the missing documentation. The DON or designee will audit all dialysis residents for concerns of missing UDA forms. The DON or designee will educate all licensed staff on completing dialysis UDA forms and auditing to ensure return UDA forms are completed upon return to the facility. The DON or designee will audit all dialysis communication forms for completion daily x3 days, then five resident charts weekly for 8 weeks. All results to be reviewed through QAPI for further recommendation.	Completion Date: 03/13/2025 Status: APPROVED Date: 02/24/2025

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F 0698 SS=D	Continued from page 104 Based on review of facility policy and clinical record and staff interview it was determined that the facility failed to make certain consistent dialysis communication was maintained for one of two dialysis residents (Resident R1). Findings include: Review of the facility policy "End-Stage Renal Disease, Care of a Resident with" dated August 2024, indicated residents with end-stage renal disease (ESRD) will be cared for according to currently recognized standards of care. Agreements between the facility and the contracted ESRD facility will include how communication between the dialysis provider and facility staff will occur. Review of Resident R1's clinical record indicated the resident was admitted to the facility on 8/19/24. Review of Resident R1's Minimum Data Set (MDS - a periodic assessment of care needs) dated 11/6/24, indicated diagnoses of peripheral vascular	F 0698		

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F 0698 SS=D	Continued from page 105 disease (progressive disorder that causes narrowing or blocking of the blood vessels outside of the heart), heart failure, and dependence on renal dialysis (blood purifying treatment given when kidney function is not optimal). Review of current physician orders on 1/24/25, indicated Resident R1 attends dialysis on Tuesday, Thursday, and Saturday each week. Further review of physician orders indicated to complete pre and post dialysis UDA (User-Defined Assessment) every day and night shift every Tuesday, Thursday, and Saturday. A review of the clinical record did not include complete communication documentation of User-Defined Assessments for the month of January 2025. There were five missing communication documentation assessments post dialysis for the following dates: 1/4/25, 1/7/25, 1/11/25, 1/14/25, and 1/18/25; and there were two missing communication documentation assessments for pre and post dialysis for the following dates: 1/2/25, and	F 0698		

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F 0698 SS=D	Continued from page 106 1/9/25. During an interview on 1/24/25, at 9:44 a.m., Registered Nurse (RN) Employee E5 confirmed that the above dates did not include completed communication documentation as required. 28 Pa. Code: 201.14(a) Responsibility of licensee. 28 Pa. Code: 201.18 (b)(1)(e)(1) Management. 28 Pa. Code: 211.10(d) Resident care policies. 28 Pa. Code: 211.12 (d)(1)(2)(5) Nursing services.	F 0698		
F 0730 SS=E		F 0730		

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F 0730 SS=E	Continued from page 107 483.35(d)(7) Nurse Aide Peform Review-12 hr/yr In-Service §483.35(d)(7) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g). This REQUIREMENT is not met as evidenced by:	F 0730	The DON or designee will ensure whole house nurse aide performance evaluations are completed by their respective nursing supervisors. The NHA will educate the DON and Human Resources Director on the annual requirement at F730- nurse aide performance reviews. The Human Resource Director or designee will audit all new employees to ensure planning of completion of annual performance reviews are completed through the facility QAPI program.	Completion Date: 03/13/2025 Status: APPROVED Date: 02/24/2025

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F 0730 SS=E	Continued from page 108 Based on review of personnel records and staff interview it was determined that the facility failed to complete annual performance evaluations for four out of four nurse aide personnel records (Nurse Aides (NA) Employee E16, NA Employee E17, NA Employee E18, and NA Employee E19). Findings include: Review of facility policy "In-Service Training, Nurse Aide" dated August 2024, indicated the facility completes a performance review of nurse aides at least every 12 months. Review of NA Employee E16's personnel record indicated a hire date of 2/6/23. Review of NA Employee E17's personnel record indicated a hire date of 7/25/22. Review of NA Employee E18's personnel record indicated a hire date of 7/30/12.	F 0730		

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F 0730 SS=E	Continued from page 109 Review of NA Employee E19's personnel record indicated a hire date of 2/7/22. Review of personnel records did not include annual performance evaluations based on the date of hire for NA Employee E16, NA Employee E17, and NA Employee E18, and NA Employee E19. Interview on 1/23/25, at 2:21 p.m. the Nursing Home Administrator confirmed that the facility failed to complete annual performance evaluations based on date of hire for NA Employee E16, NA Employee E17, NA Employee E18, and NA Employee E19. 28 Pa Code: 201.14 (a) Responsibility of licensee 28 Pa Code: 201.18 (b)(1)(3) Management	F 0730		

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F 0742 SS=D	483.40(b)(1) Treatment/Srvcs Mental/Psychosocial Concerns §483.40(b) Based on the comprehensive assessment of a resident, the facility must ensure that- §483.40(b)(1) A resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder, receives appropriate treatment and services to correct the assessed problem or to attain the highest practicable mental and psychosocial well-being; This REQUIREMENT is not met as evidenced by:	F 0742	Resident R94 remains at the facility pending discharge home on 2/10/25. Resident R94 declined behavioral health consult when offered? No negative outcome has been identified as a result of the lack of an as needed behavioral consult. All residents with an "as needed" behavioral consult care plan will be reviewed for behaviors or willingness to receive behavioral care consults. The NHA will educate all social services employees on the social services policy. The Social Services Director or designee will audit any residents requesting behavioral health referrals to ensure the referrals are generated in a timely manner from date of request. Audits will be completed weekly x 8 weeks. All results to be reviewed through QAPI for further recommendation.	Completion Date: 03/13/2025 Status: APPROVED Date: 02/24/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395845	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/24/2025	
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F 0742 SS=D	Continued from page 111 Based on review of facility policy, resident and staff interview and clinical record review the facility failed to maintain the highest practicable mental and psychosocial well-being for one of three residents (Resident R94). Findings include: Review of the facility policy "Social Services" dated 8/20/24, indicated: "Our facility provides medially-related social services to assure that each resident can attain or maintain his/her highest practicable physical, mental, or psychosocial well-being. The social worker/social services staff are responsible for: making referrals and obtaining needed services from outside entities Resident R94 was admitted on 11/7/24. Resident R94 MDS (minimum data set - a periodic assessment of resident needs) dated 11/13/24, indicated diagnoses diabetes mellitus (a group of diseases that result in too much sugar in the blood),	F 0742		

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F 0742 SS=D	Continued from page 112 anxiety (a mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities), and depression (mood disorder that causes a persistent feeling of sadness and loss of interest and can interfere with one's daily life). Review of Resident R94 clinical record indicated the following : Care plans indicated Resident R94 has a mood problem related to depression anxiety: behavioral health consults as needed. Monitor/record/report to physician, as needed acute episode feelings or sadness; loss of pleasure and interest in activities; feelings of worthlessness or guilt; change in appetite/eating habits; change in sleep patterns; diminished ability to concentrate; change in psychomotor skills. Review of the clinical record failed to include any behavioral health consult.	F 0742		

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F 0742 SS=D	Continued from page 113 During an interview on 1/23/25, at 10:59 a.m. Social Service Director Employee E2 confirmed the facility had not sent any referrals for behavioral health services and the facility failed to maintain the highest practicable mental and psychosocial well-being for Resident R94. 28 Pa. Code: 201.14(a) Responsibility of licensee. 28 Pa. Code: 201.18(b)(1)(e) (1) Management. 28 Pa. Code: 211.10(d)Resident care policies. 28 Pa. Code: 211.12(d)(1)(2)(5) Nursing services.	F 0742		
F 0755 SS=D		F 0755		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395845	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/24/2025	
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F 0755 SS=D	Continued from page 114 483.45(a)(b)(1)-(3) Pharmacy Srvcs/Procedures/Pharmacist/Records §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.	F 0755	Medications were picked up for disposal by the pharmacy at the time of survey. All medication rooms were audited for medications awaiting pickup disposal at the time of survey. The facility has implemented a carbon copy pharmacy form system for medication reconciliation/disposal as well as a pharmacy request form if medication volume requires more frequent pick up for disposal. The DON or designee will educate all licensed nursing staff on the new forms, reconciliation and disposal process. The DON or designee will audit the medication rooms for proper use of the new reconciliation/disposal system daily for 3 days and then weekly x 8 weeks. All results to be reviewed through QAPI for further recommendation.	Completion Date: 03/13/2025 Status: APPROVED Date: 02/24/2025

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F 0755 SS=D	Continued from page 115 This REQUIREMENT is not met as evidenced by:	F 0755			

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F 0755 SS=D	<p>Continued from page 116</p> <p>Based on review of facility policy, observation and staff interview it was determined the facility failed to dispose or reconcile discontinued medication in a timely manner for one of two medication rooms reviewed (West Medication Room).</p> <p>Findings:</p> <p>Review of facility "Storage of Medications" policy dated 8/24, indicated that the facility stores all drugs and biologicals in a safe, secure, and orderly manner. Drugs and biologicals used in the facility are stored in locked compartments under proper temperature, light and humidity control. Only persons authorized to prepare and administer medications have access to locked medications. Discontinued, outdated, or deteriorated drugs or biologicals are returned to the dispensing pharmacy or destroyed.</p> <p>Review of facility "Discarding and Destroying Medication" policy dated 8/24, indicated that medications will be disposed of in accordance with</p>	F 0755		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395845	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/24/2025	
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F 0755 SS=D	Continued from page 117 federal, state, and local regulations governing management of non-hazardous pharmaceuticals, hazardous wates, and controlled substances. Completed medication disposition records shall be kept on file in the facility. The medication disposition record will contain the following information: - The residents name - Date medication disposed - The name and strength of the medication - The quantity disposed - Method of disposition - Reason for disposition - Signature of witnesses During a medication room review on 1/22/25, at 11:30 a.m. one grey plastic basin with medications was observed sitting on the counter, unsecured and unaccounted for. The medications observed were: - Neurontin (used to treat seizures or pain) 274 pills - Levemir Vial (used to manage diabetes - a metabolic disorder in which the body has high sugar	F 0755		

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F 0755 SS=D	Continued from page 118 levels for prolonged periods of time) 1 vial - Lantus Pen (used to manage diabetes) 1 pen - Amlodipine (used to treat high blood pressure) 12 pills - Ibuprofen (used to treat pain) 8 pills - Coumadin (used to treat heart conditions or blood clots) 15 pills - Eliquis (used to treat heart conditions or blood clots)1 pill - Tylenol (used to treat pain) 120 pills - Motrin (used to treat pain) 49 pills - Zyrtec (used to treat allergies) 30 pills - Senna (used to treat constipation) 29 pills - Lipitor (used to treat high fat levels in the blood) 21 pills - Remeron (used to treat depression) 21 pills - Metoprolol (used to treat high blood pressure) 18 pills - Prednisone (used to treat inflammation) 3 pills - Mucinex (used for congestion) 20 pills - Ezetimibe (used to treat high fat levels in blood) 19 pills - Keflex (used to treat an infection) 10 pills	F 0755		

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F 0755 SS=D	Continued from page 119 - Nitroglycerin (used for heart conditions) 7 patches and 1 bottle - Lopressor (used to treat high blood pressure 16 pills - Cymbalta (used to treat depression) 24 pills - Simethicone (used to treat gas) 100 pills - Rocephin (used to treat infection) 1 bag - Miralax (used for constipation) 5 bottles - Milk of Magnesia (used for constipation) 9 bottles - Ertapenem (used to treat infection) 3 bags - Lispro vial (used to treat diabetes) 1 vial - Humalog (used to treat diabetes) 1 pen - Voltaren Gel (cream used for pain) 1 tube - Delsym (used for coughing) 1 bottle During an interview on 1/22/25, at 11:25 p.m. Director of Nursing (DON) stated, "These are medications that get sent back to pharmacy. They pick up maybe once a week. We don't have any paperwork to fill out. The nurses discontinue the medication in the computer, pull it from their carts and put them in this bin. We don't have any accountability or disposition forms to fill out".	F 0755		

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F 0755 SS=D	Continued from page 120 During an interview on 1/22/25, at 11:30 a.m. the DON confirmed that the facility failed to dispose or reconcile discontinued medication in a timely manner for one of two medication rooms reviewed (West Medication Room). 28 Pa. Code211.12(d)(1)(3)(5) Nursing services.	F 0755		
F 0758 SS=D		F 0758		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395845	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/24/2025	
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F 0758 SS=D	Continued from page 121 483.45(c)(3)(e)(1)-(5) Free from Unnec Psychotropic Meds/PRN Use §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and	F 0758	Resident R108 remains at the facility with no adverse outcomes. All residents receiving psychotropic medications will be audited to ensure residents have proper clinically indicated diagnosis for use. All licensed nursing staff will be educated on the clinically indicated use of psychotropics including proper diagnosis for use. The DON or designee will audit all psychotropics being used in the facility for proper diagnosis. Audits will be completed weekly x8. All results to be reviewed through QAPI for further recommendation.	Completion Date: 03/13/2025 Status: APPROVED Date: 02/24/2025

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F 0758 SS=D	Continued from page 122 §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by:	F 0758		

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F 0758 SS=D	Continued from page 123 Based on facility policy review and clinical record review, and staff interview, it was determined that the facility failed to make certain that residents receiving psychotropic medications have adequate indication for use for one of five sampled residents (Resident R108). Findings include: Review of the facility policy "Medication and Treatment Orders" dated August 2024, indicated orders for medications must include name and strength of the drug, number of doses, dosage and frequency of administration, route, clinical condition for which the medication is prescribed. Review of the admission record indicated Resident R108 was admitted to the facility on 12/30/24. Review of Resident R108's Minimum Data Set (MDS- a periodic assessment of care needs) dated 1/5/25, indicated the diagnoses of atrial fibrillation (irregular heart rhythm), heart failure (heart doesn't	F 0758		

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F 0758 SS=D	Continued from page 124 pump blood as well as it should), high blood pressure, and anxiety disorder. Review of Resident R108's physician orders dated 12/30/24, indicated quetiapine (an antipsychotic medication) 25 mg (milligrams) twice daily for anxiety. Review of Resident R108's Medication Administration Record (MAR) dated January 2025, indicated resident was receiving the medication as prescribed. Interview on 1/24/25, at 1:00 p.m. the Nursing Home Administrator confirmed the facility failed to have an appropriate diagnosis for the use of the antipsychotic medication quetiapine. Interview on 1/24/25, at 3:15 p.m. the Director of Nursing confirmed the facility failed to make certain that residents receiving psychotropic medications have adequate indication for use for one of five sampled residents (Resident R108).	F 0758		

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F 0758 SS=D	Continued from page 125 28 Pa. Code: 201.14(a) Responsibility of licensee. 28 Pa. Code: 201.18(a)(b)(3) Management. 28 Pa. Code: 211.12 (d)(1)(3)(5) Nursing services.	F 0758		
F 0761 SS=D		F 0761		

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F 0761 SS=D	Continued from page 126 483.45(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	All items listed were removed and disposed of. The pharmacy came in and serviced the narcotic lock on the medication cart at the time of survey. All carts and medication rooms were audited for expired medications and biologicals, medications were checked for proper labeling, and narcotic boxes were checked to ensure locks were working correctly at the time of survey. The DON or designee will educate all licensed staff on the process of contacting the pharmacy for medication cart locking issues, disposing of expired medications and biologicals, and proper labeling of medications. The DON or designee will audit all medication rooms and carts for properly labeled or expired medications and biologicals, and proper locking of medication carts. Audits will be completed daily x3 and then weekly x 8. All results to be reviewed through QAPI for further recommendation.	Completion Date: 03/13/2025 Status: APPROVED Date: 02/24/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395845	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/24/2025	
NAME OF PROVIDER OR SUPPLIER: CRANBERRY PLACE STATE LICENSE NUMBER: 381602		STREET ADDRESS, CITY, STATE, ZIP CODE: 5 ST. FRANCIS WAY CRANBERRY TOWNSHIP, PA 16066		
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F 0761 SS=D	Continued from page 127 Based on review of facility policy, observations, and staff interviews, it was determined that the facility failed to properly store medical supplies in two of four medication carts (North Front Med Cart, and West Med Cart) and failed to properly store medical supplies and biologicals in one of two medication rooms (North medication room). Findings: Review of facility "Storage of Medications" policy dated 8/24, indicated that the facility stores all drugs and biologicals in a safe, secure, and orderly manner. Drugs and biologicals used in the facility are stored in locked compartments under proper temperature, light and humidity control. Only persons authorized to prepare and administer medications have access to locked medications. Discontinued, outdated, or deteriorated drugs or biologicals are returned to the dispensing pharmacy or destroyed. Insulin pens are clearly labeled with the resident's name.	F 0761		

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F 0761 SS=D	<p>Continued from page 128</p> <p>During a medication cart review on 1/22/25, at 9:45 a.m. the narcotic lock box on the North Front medication cart was not locked and there was an expired insulin Lispro (used to treat diabetes - a metabolic disorder in which the body has high sugar levels for prolonged periods of time) pen stored on the cart.</p> <p>During an interview on 1/22/25, at 9:45 a.m. Registered Nurse (RN) Employee E5 confirmed that the narcotic drawer was not locked and there was an expired insulin pen on the cart.</p> <p>During a medication cart review on 1/22/25, at 11:00 a.m. it was observed on the West medicine cart that there was one insulin Lantus (used to treat diabetes) pen on the cart that had the name blackened out and unable to determine whose medication it belonged to.</p> <p>During an interview on 1/22/25, at 11:02 a.m. Licensed Practical Nurse (LPN) Employee E13 confirmed that the insulin pen did not have a legible</p>	F 0761		

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F 0761 SS=D	<p>Continued from page 129</p> <p>residents name on.</p> <p>During an observation completed on 1/22/25, at 10:32 a.m. the North Hall medication rooms refrigerator contained an opened bottle of Elmo Pio sweet peach wine. The wine failed to be labeled with a name or date opened.</p> <p>During an interview completed on 1/22/25, at 10:34 a.m. LPN Employee E8 confirmed the wine stored in the refrigerator was not labeled with a name or date opened and that the facility failed to properly store medical supplies and biologicals in one of two medication rooms (North medication room).</p> <p>During an interview on 1/22/25, at 3:00 p.m. the Director of Nursing confirmed that the facility failed to properly store medical supplies in two of four medication carts (North Front Med Cart, and West Med Cart).</p> <p>28 Pa Code: 211.9 (a) Pharmacy services. 28 Pa code: 211.12 (d) (1) (5) Nursing services.</p>	F 0761		

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F 0761 SS=D	Continued from page 130	F 0761		
F 0805 SS=D		F 0805		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395845	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/24/2025
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F 0805 SS=D	Continued from page 131 483.60(d)(3) Food in Form to Meet Individual Needs §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(3) Food prepared in a form designed to meet individual needs. This REQUIREMENT is not met as evidenced by:	F 0805	Tickets will be highlighted to alert dietary staff of varied consistency of food items to residents. Dietary staff will be educated regarding the highlighting of tray tickets to alert consistency needs per tray line and IDDS framework of diets. Daily audits of tickets and trays 10 per day per meal for 2 weeks, then bimonthly for 1 month. Audit results will be reviewed through QAPI for further recommendations. 2/25/25 The dietary supervisor performed an internal audit on ALL "resident tray tickets" and compared them against the resident's current prescribed Diet order, to ensure all resident tray tickets were accurate and "up-to-date". (diet, consistency, alerts and resident specific items) Education completed with all dietary staff to ensure order diet/ticket items are included on all trays. Education completed with dietary staff on the "IDDS framework of diets" and also, how to properly highlight the resident tickets to alert other staff of the varied food consistencies and other resident specific items	Completion Date: 03/13/2025 Status: APPROVED Date: 02/25/2025

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F 0805 SS=D	Continued from page 132	F 0805	(weighted utensil; dived dish; bowls..ect). Daily audit of tickets and trays 10 per day per meal for 2 weeks, then bimonthly for 1 month. Audit results will be reviewed through QAPI for further recommendations.	

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F 0805 SS=D	<p>Continued from page 133</p> <p>Based on facility policy, observation, and staff interviews, it was determined that the facility failed to provide food in a form to meet individuals' needs in one of three residents ordered a soft and bite size diet (Resident R42).</p> <p>Findings include:</p> <p>Review of the facility policy "Therapeutic Diets" dated 8/24, indicated that therapeutic diets are prescribed by the attending physician to support the resident's treatment and plan of care and in accordance with his or her goals and preferences. A therapeutic diet is considered a diet ordered as part of treatment for a disease or clinical condition, to modify specific nutrients in the diet, or to alter the texture of a diet.</p> <p>Review of the clinical record revealed that Resident R42 was admitted to the facility on 8/1/23.</p> <p>Review of Resident R42's MDS (Minimum Data Set, periodic assessment of resident care needs)</p>	F 0805		

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F 0805 SS=D	<p>Continued from page 134</p> <p>dated 12/6/24, indicated diagnoses of high blood pressure, dementia (a group of symptoms that affects memory, thinking and interferes with daily life), and Parkinson's disease (neuromuscular disorder causing tremors and difficulty walking).</p> <p>Review of Resident R42's physician's orders on 1/16/25, indicated that resident was ordered a soft and bite size diet.</p> <p>During an observation on 1/21/25, at 12:43 p.m. Resident R42 was observed in the dining room with a lunch tray that was pureed food (soup like) consistency. Resident R42's meal ticket stated he should have received a soft and bite size food consistency diet for lunch. Resident R42 was also missing his milk on his tray.</p> <p>During an interview on 1/21/25, at 12:47 Nursing Assistant Employee E6 stated that Resident R42's tray looked like it was pureed food consistency, did not match what he was ordered, and stated "I should have called the kitchen to tell them to bring</p>	F 0805		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395845	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/24/2025
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F 0805 SS=D	Continued from page 135 him another lunch tray". During an interview on 1/21/25, at 12:55 p.m. the Dietary Manager Employee E3 confirmed that the facility failed to provide food in a form to meet individuals' needs in one of three residents ordered a soft and bite size diet (Resident R42). 28 Pa. Code: 211.6(d) Dietary services.	F 0805		
F 0809 SS=D		F 0809		

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F 0809 SS=D	Continued from page 136 483.60(f)(1)-(3) Frequency of Meals/Snacks at Bedtime §483.60(f) Frequency of Meals §483.60(f)(1) Each resident must receive and the facility must provide at least three meals daily, at regular times comparable to normal mealtimes in the community or in accordance with resident needs, preferences, requests, and plan of care. §483.60(f)(2) There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except when a nourishing snack is served at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span. §483.60(f)(3) Suitable, nourishing alternative meals and snacks must be provided to residents who want to eat at non-traditional times or outside of scheduled meal service times, consistent with the resident plan of care. This REQUIREMENT is not met as evidenced by:	F 0809	There were no negative outcomes noted. Dietary staff will be educated by Dietary Manager on assuring all the items for the tray line are collected 15 min ahead of the start time of meal. Dietary supervisors will audit timeliness of meals daily for 2 weeks then bimonthly. All results to be reviewed through QAPI for further recommendation. 2/25/25 Dietary manager reeducated ALL dietary staff on what time trays are to be expected to arrive on each unit. All Dietary staff to be educated by the Dietary Manager on ensuring all items for the tray line are prepped 15min ahead of the start of the meal. Dietary supervisor will audit timeliness of meals daily for 2 weeks, then 2x week for 2 weeks, then bimonthly until substantial compliance is met. All results will be reviewed through QAPI for further recommendations.	Completion Date: 03/13/2025 Status: APPROVED Date: 02/25/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395845	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/24/2025	
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F 0809 SS=D	Continued from page 137 Based on review of facility meal delivery times, observations and staff interview, it was determined that the facility failed to deliver meals in a timely manner for one of two meal observations (West Rooms 374-387). Findings include: Review of the facility provided tray schedule, indicated lunch start time is at 11:00 a.m. More specifically, West 2 (Rooms 374-387) cart number 8 is 12:05 p.m. During dining/meal observations on 1/21/25, at 12:00 p.m. of the West Hallway Rooms 374-387, it was revealed that the lunch trays did not arrive until 12:32 p.m. Trays arrived 27 minutes late. Interview on 1/21/25, at 12:33 p.m. Nurse Aide (NA) Employee E20 confirmed the time of tray arrival to be 12:32 p.m. Interview on 1/21/25, at 12:40 p.m. Registered	F 0809		

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F 0809 SS=D	Continued from page 138 Nurse (RN) Employee E21 indicated tray arrival time varies since the change in management, and the loss of multiple dietary personnel. During an interview on 1/24/25, at 3:15 p.m. the Director of Nursing confirmed the facility failed to deliver meals in a timely manner for one of two meal observations (West Rooms 374-387). 28 Pa. Code: 201.18(e)(4) Management 28 Pa. Code: 201.29(i) Resident Rights	F 0809		
F 0810 SS=D		F 0810		

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F 0810 SS=D	Continued from page 139 483.60(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	There were no negative outcomes as a result of missing adaptive utensils and sippy cup lid. Dietary staff will be educated by the dietary manager on adaptive equipment and the F810 tag. Audits will be done daily for 2 weeks by dietary supervisor. Bimonthly for two months. All results to be reviewed through QAPI for further recommendation.2/25/25 Dietary manager educated all dietary staff on each type of resident adaptive equipment and the importance of ensuring all adaptive equipment is present on each resident tray for every meal as ordered. Audits to be performed by the dietary supervisor, checking that each resident's specific adaptive equipment is: listed on the tray ticket and that the item is visible on the resident tray. Audit to be performed daily for 2 weeks, then monthly for two months. All results will be reviewed through QAPI for further recommendations.	Completion Date: 03/13/2025 Status: APPROVED Date: 02/25/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395845	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/24/2025	
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F 0810 SS=D	<p>Continued from page 140</p> <p>Based on observations, and staff interviews it was determined that the facility failed to provide adaptive feeding devices for one of three residents (Resident R42).</p> <p>Findings include:</p> <p>Review of the admission record indicated Resident R42 admitted to the facility on 8/1/23.</p> <p>Review of Resident R42's Minimum Data Set (MDS- a periodic assessment of care needs) dated 12/6/24, indicated diagnoses of high blood pressure, dementia (a group of symptoms that affects memory, thinking and interferes with daily life), and Parkinson's disease (neuromuscular disorder causing tremors and difficulty walking).</p> <p>Review of Resident R42's current physician orders indicated a soft and bite size diet with thin liquids.</p> <p>Review of Resident R42's care plan dated 1/20/25, indicated to use a two handled sippy cup with spout,</p>	F 0810		

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F 0810 SS=D	Continued from page 141 sippy lid. During an observation on 1/22/25, at 12:15 p.m. Resident R42 was in the dining room set up for lunch and was eating. The meal ticket indicated spouted cup. During an interview and observation on 1/22/25, at 12:17 p.m. Dietary Director Employee E3 indicated a spouted cup was not served as ordered on the tray, one regular cup was present. During an interview on 1/22/25, at 3:00 p.m. the Director of Nursing confirmed the facility failed to provide adaptive feeding devices for one of three residents (Resident R42). 28 Pa. Code: 211.6(a) Dietary services. 28 Pa Code: 201.29 (d) Resident rights.	F 0810		

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F 0880 SS=D		F 0880		
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395845	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/24/2025	
NAME OF PROVIDER OR SUPPLIER: CRANBERRY PLACE STATE LICENSE NUMBER: 381602		STREET ADDRESS, CITY, STATE, ZIP CODE: 5 ST. FRANCIS WAY CRANBERRY TOWNSHIP, PA 16066		
(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 0880 SS=D	Continued from page 143 483.80(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	Resident R53's urinary draining bag was changed and secured properly at the time of survey. Resident R54 was placed in Enhanced Barrier Precautions at the time of survey. Resident R54's wound has since been examined and has had no negative impact from the lack of EBP during the dressing change. The bedside table was sanitized after being notified by the surveyor. A whole house sweep was conducted at the time of survey to ensure all urinary drainage bags were being properly secured for infection control purposes. A whole house audit was completed at the time of survey to ensure all residents meeting the criteria for EBP were ordered with proper signage present. The DON or designee will educate all licensed staff on sanitizing the bedside table after dressing changes and indications for implementing EBP for residents. All nursing staff will be educated in infection control as it relates to urinary drainage bags.	Completion Date: 03/13/2025 Status: APPROVED Date: 02/25/2025

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F 0880 SS=D	Continued from page 144 (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	The DON or designee will audit one dressing change daily x 3 days, then one dressing change weekly x 8 weeks. All results to be reviewed through QAPI for further recommendation. 2/25/25 R53's urinary drainage bag was changed and secured properly at the time of survey, Resident R54 was placed in Enhanced Barrier Precautions immediately at the time of survey. Resident R54's wound has since been examined and has not had any negative impact from the lack of EBP during the dressing change. The bedside table was sanitized immediately after being notified by the surveyor. A whole house sweep was conducted at the time of survey to ensure all urinary drainage bags were being properly secured for infection control purposes. A whole house audit was completed at the time of survey to ensure all residents meeting criteria for EBP were ordered isolation precautions and had proper signage in place. The DON or designee will educate all licensed staff on sanitizing the bedside table	

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F 0880 SS=D	Continued from page 145	F 0880	after dressing changes and indications for implementing EBP for residents. All nursing staff will be reeducated on Infection Control and how it relates to urinary drainage bags. The DON or designee will audit one dressing change daily x3days, then one dressing change weekly x8weeks. All results to be reviewed through QAPI for further recommendation. The infection preventionist will continue to perform ongoing twice weekly audits to ensure all residents on Enhanced Barrier Precautions have appropriate orders/signage/supplies in place/present for use. All results will be reviewed through QAPI for further recommendations.	

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F 0880 SS=D	Continued from page 146 Based on review of facility policy, observations, and staff interviews, it was determined that the facility failed to maintain proper infection control practices related to care of indwelling urinary catheters (tube inserted in the bladder to drain urine) for one of three residents reviewed (Residents R53), failed to prevent cross contamination during a dressing change for one of three residents (Resident R54) and failed to follow enhanced barrier precautions for one of five residents (Resident R54). Findings include: Review of facility policy "Catheter Care, Urinary", dated August 2024, indicated this procedure is to prevent catheter-associated complications, including urinary tract infections. Be sure the catheter tubing and drainage bag are kept off the floor. Review of the facility policy "Dressings, Dry/Clean", dated August 2024, indicates the purpose of this procedure is to provide guidelines for the application of dry, clean dressings. Steps in the procedure (1	F 0880		

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F 0880 SS=D	Continued from page 147 thru 24) include but not inclusive to: Step number 1 is to clean bedside stand. Establish a clean field. Step number 22 is to clean the bedside stand. Review of the facility policy "Enhanced Barrier Precautions", dated August 2024, indicate enhanced barrier precautions (EBP's) are utilized to prevent the spread of multi-drug resistant organism (MDROs). EBP's are indicated for residents with wounds and indwelling medical devices. EBP's remain in place for the duration of the residents stay or until resolution of the wound. Review of Resident R53's clinical record indicated he was admitted to the facility on 3/13/24. Review of Resident R53's Minimum Data Set (MDS - a periodic assessment of care needs) dated 12/20/24, indicated diagnoses of quadriplegia (a symptom of paralysis that effects all limbs and body from the neck down), chronic pulmonary disease, and anxiety disorder. MDS section H0100 is coded	F 0880		

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F 0880 SS=D	Continued from page 148 that an indwelling catheter appliance is used. Review of a physician order dated 10/30/24, indicated Resident R53 has a foley catheter for neurogenic bladder. During an observation on 1/21/25, at 12:49 p.m., Resident R53's catheter collection bag, contained within a dignity cover, was observed lying on the floor on the left side of resident's bed. During an interview on 1/21/25, at 12:51 p.m., Registered Nurse (RN) Employee E5 confirmed Resident R53's catheter collection bag was lying on the floor on the left side of resident's bed. Review of Resident R54's clinical record indicates an admission date of 11/10/22. Review of Resident R54's MDS dated 10/25/24, indicates the diagnosis of anemia (low iron in the blood), coronary artery disease (CAD- buildup of plaque in the hearts arteries), and hypertension (high	F 0880		

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F 0880 SS=D	Continued from page 149 blood pressure). Review of Resident R54's physician orders dated 1/21/25, indicate wound care right buttocks every day shift. Cleanse with NSS (normal sterile saline) and pat dry. Apply Medi honey (medical grade honey used to treat wounds) and cover with dry dressings. Resident R54's physician orders failed to include orders for enhanced precautions. Observation on 1/22/25, at 10:39 a.m. Licensed Practical Nurse (LPN) Employee E8 entered resident R54's room along with Nurse Aid (NA) Employee E14 to complete dressing change. The room did not have any signage up indicating the need to stop and see nurse before entering or the need to utilize personal protective equipment (PPE). LPN Employee E8 and NA E14 continued to complete the dressing change. Upon completion of dressing change LPN Employee E8 and NA Employee E14 exited the room. LPN Employee E8 failed to clean the bedside stand.	F 0880		

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F 0880 SS=D	<p>Continued from page 150</p> <p>Upon inquiring about enhanced precaution Employee E8 confirmed there was no sign on the door or orders to indicate the use of enhanced precautions for Resident R54 and she was not aware of the need to utilize enhanced precautions for Resident R54's wound care.</p> <p>During an interview completed on 1/22/25 at 10:54 a.m. LPN Employee E8 confirmed not cleansing the bedside stand after completion of the dressing change and not utilizing enhanced barrier precautions during the dressing change and that the facility failed to prevent cross contamination during a dressing change for one of three residents and failed to follow enhanced barrier precautions for one of five residents (Resident R54).</p> <p>During an interview completed on 1/22/25 at 11:28 Registered Nurse Infection Preventionist Employee E11 stated that enhanced precautions were not ordered for Resident R54, and that the facility failed to follow enhanced barrier precautions for one of five residents (Resident R54).</p>	F 0880		

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F 0880 SS=D	Continued from page 151 28 Pa. code: 201.14 (a) Responsibility of licensee. 28 Pa. Code: 201.18 (b) (1) (e) (1) Management. 28 Pa. Code: 211.10 (d) Resident care policies. 28 Pa. Code: 211.12 (d) (1) (2) (5) Nursing services.	F 0880			

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H 0005	<p>51.3 (c) NOTIFICATION</p> <p>51.3 Notification</p> <p>(c) A health care facility shall provide similar notice at least 60 days prior to the effective date it intends to cease providing an existing health care service or reduce it licensed bed complement.</p> <p>This REGULATION is not met as evidenced by:</p>	H 0005	<p>The 2 Beds immediately were returned to rooms. Staff will be educated by regional nurse on tag 005. Beds will be audited 3 times a week for four weeks then monthly. All results to be reviewed through QAPI for further recommendation.</p>	<p>Completion Date: 03/13/2025 Status: APPROVED Date: 02/24/2025</p>
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE:		(X6) DATE:

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H 0005	Continued from page 1 Based on facility records, observations and staff interview it was determined that the facility failed to provide notification to the department that it had reduced the number of licensed beds in operation. Findings include: The facility bed readout document (a document showing the number of beds licensed in the facility) indicated two Medicare/Medicaid licensed beds on the North Front Hall nursing unit in the following rooms: 244, and 248. During observations of the North Front Hall nursing unit on 1/23/25, at 9:30 a.m. the following was observed: -The North Front Hall nursing unit only had one bed in room 244 Window and was missing the door bed. -The North Front Hall nursing unit only had one bed in room 248 Window and was missing the door	H 0005		

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H 0005	Continued from page 2 bed. During an interview on 1/23/25, at 10:10 a.m. Nursing Home Administrator (NHA) confirmed that the above rooms were missing licensed beds and that the facility failed to provide notification to the Department that it had reduced the number of licensed beds.	H 0005			

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P 1440	Personnel policies and procedures. (1) The employee's job description, educational background and employment history. This REGULATION is not met as evidenced by:	P 1440	All personal files were reviewed by HR to ensure completion of job descriptions with a signature. Personal files will be reviewed weekly by HR and Administrator for 6 weeks, then monthly. All results to be reviewed through QAPI for further recommendation. 2/25/25All personal files were reviewed by HR to ensure completion of job descriptions with staff signatures. Personal files will be reviewed weekly by HR and the Administrator for 6 weeks, then monthly. All newly hired staff to sign off on their job description during the "hiring process". All results to be reviewed through QAPI for further recommendations.	Completion Date: 03/13/2025 Status: APPROVED Date: 02/25/2025
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P 1440	Continued from page 1 Based on review of employee personnel records and staff interview, it was determined that the facility failed to ensure personnel records included a copy of the employee's signed job description for four of five personnel files reviewed (Employees Nurse Aides (NA) Employee E22, NA Employee E23, Registered Nurse (RN) Employee E24, and RN Employee E25. Findings include: Review of the personnel files on 1/24/25, at 10:40 a.m. indicated the hire date of all five employees to be as follows: NA Employee E22's original hire date 1/13/25. NA Employee E23's original hire date 1/13/25. RN Employee E24's original hire date 1/13/25. RN Employee E25's original hire date 12/9/24. Upon review of the employees' job descriptions, on 1/24/25, at 10:40 a.m. the employee files failed to	P 1440		

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P 1440	Continued from page 2 include a signed job description for each staff. Interview on 1/24/25, at 10:46 a.m. the Nursing Home Administrator confirmed the facility failed to ensure personnel records included a copy of the employee's signed job description for four of five personnel files reviewed (Employees NA Employee E22, NA Employee E23, RN Employee E24, and RN Employee E25.	P 1440		
P 1490		P 1490		

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P 1490	Continued from page 3 Personnel policies and procedures. (6) Documentation of the employee's orientation to the facility and the employee's assigned position prior to or within 1 week of the employee's start date. This REGULATION is not met as evidenced by:	P 1490	All personal files were reviewed for completion. Education will be provide to the educator on timely completion of new hire paperwork. Audits will be completed by HR weekly for 8 weeks then monthly. All results to be reviewed through QAPI for further recommendation. 2/25/25 All personal files were reviewed by HR to ensure completion of job descriptions with staff signatures. Personal files will be reviewed weekly by HR and the Administrator for 6 weeks, then monthly. All newly hired staff to sign off on their job description during the "hiring process". All results to be reviewed through QAPI for further recommendations.	Completion Date: 03/13/2025 Status: APPROVED Date: 02/25/2025

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P 1490	Continued from page 4 Based on review of employee personnel records and staff interview, it was determined that the facility failed to ensure personnel records included evidence that employees received orientation to the facility and the employee's assigned position prior to or within one week of the employee's start date for four of five personnel files reviewed (Employees Nurse Aides (NA) Employee E22, NA Employee E23, NA Employee E26, and Registered Nurse (RN) Employee E24). Findings include: Review of the personnel files on 1/24/25, at 10:40 a.m. indicated the hire date of all four employees to be as follows: NA Employee E22's original hire date 1/13/25. NA Employee E23's original hire date 1/13/25. NA Employee E26's original hire date 1/13/25. RN Employee E24's original hire date 1/13/25. Review of the employees' files, on 1/24/25, at 10:40	P 1490		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395845	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/24/2025
NAME OF PROVIDER OR SUPPLIER: CRANBERRY PLACE STATE LICENSE NUMBER: 381602		STREET ADDRESS, CITY, STATE, ZIP CODE: 5 ST. FRANCIS WAY CRANBERRY TOWNSHIP, PA 16066		
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P 1490	Continued from page 5 a.m. the employee files failed to include a completed orientation as required. The files indicated the employees' are currently in orientation. Interview on 1/24/25, at 10:46 a.m. the Nursing Home Administrator confirmed the facility failed to ensure personnel records included evidence that employees received orientation to the facility and the employee's assigned position prior to or within one week of the employee's start date for four of five personnel files reviewed (Employees NA Employee E22, NA Employee E23, NA Employee E26, and RN Employee E24).	P 1490		
P 4920		P 4920		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395845	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/24/2025
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P 4920	Continued from page 6 Dietary Services. (a) Menus shall be planned and posted in the facility or distributed to residents at least 2 weeks in advance. Records of menus of foods actually served shall be retained for 30 days. When changes in the menu are necessary, substitutions shall provide equal nutritive value. This REGULATION is not met as evidenced by:	P 4920	2 weeks' worth of menus were hung in the dining room, each resident was given a copy of the menu. Education was provided to the Dietary staff by the NHA on tag 4920. audits will be done weekly for 8 weeks then monthly by the NHA. All results to be reviewed through QAPI for further recommendation. 2/25/25 All employee files reviewed for completion of all orientation paperwork. Education provided to the educator on the importance of completing new hire paperwork in a timely manner. Internal audit to be performed by HR on ALL current employees to ensure all new hire paperwork is accurate and complete. HR will then perform monthly audits until substantial compliance is met. All results will be reviewed through QAPI for further recommendations.	Completion Date: 03/13/2025 Status: APPROVED Date: 02/25/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395845	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/24/2025
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P 4920	Continued from page 7 Based on observations, resident interview, and staff interview, it was determined the facility failed to post menus in the facility or distribute to residents at least two weeks in advance for all nursing units of the facility (East, West, and North). Findings include: Tour of the facility on 1/21/25, at 2:00 p.m., revealed that the facility had provided their daily menu options only on East, West, and North units as observed. During an interview on 1/22/25, at 8:55 a.m., Dietary Manager (DM) Employee E3 confirmed that the facility only posted their daily menu, and the facility failed to post menus in the facility or distribute to residents at least two weeks in advance as required.	P 4920		
P 5520		P 5520		

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P 5520	Continued from page 8 Nursing services. (3) Effective July 1, 2024, a minimum of 1 nurse aide per 10 residents during the day, 1 nurse aide per 11 residents during the evening, and 1 nurse aide per 15 residents overnight. This REGULATION is not met as evidenced by:	P 5520	The scheduler was educated on tag 5520 by the facility NHA. The facility DON will monitor CNA ratios daily until substantial compliance is met. Currently offering an attendance bonus, ongoing hiring of CNA and Nurses through Indeed, Sign on bonus, and a referral bonus. All results to be reviewed through QAPI for further recommendation.	Completion Date: 03/13/2025 Status: APPROVED Date: 02/27/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395845	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/24/2025
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P 5520	Continued from page 9 Based on review of nursing schedules, nursing staffing documents and staff interview, it was determined that the facility failed to provide the State required minimum of one Nurse Aide (NA) per 10 residents on the daylight shift for six out of 21 days (1/3/25, 1/5/25, 1/6/25, 1/9/25, 1/17/25, and 1/18/25), and failed to provide the State required minimum of one NA per 11 residents on two out of 21 evening shifts (1/10/25, and 1/17/25), and failed to provide the State required minimum of one NA per 15 residents on four of 21 midnight shifts (1/6/25, 1/8/25, 1/11/25, and 1/13/25). Findings include: Review of the facility's 3-week nurse staffing schedules (1/3/25, - 1/23/25) did not include the State required minimum of Nurse Aides (NA) on: -Daylight shift: 1/3/25, needed 11.5 and only had 11. Census was 115. 1/5/25, needed 11.5 and only had 9. Census was	P 5520		

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P 5520	Continued from page 10 115. 1/6/25, needed 11.4 and only had 9.5. Census was 114. 1/9/25, needed 11.9 and only had 11.5. Census was 119. 1/17/25, needed 12 and only had 10.3. Census was 120. 1/18/25, needed 12 and only had 10.3. Census was 120. -Evening shifts: 1/10/25, needed 10.64 and only had 8.94. Census was 117. 1/17/25, needed 10.91 and only had 10.89. Census was 120. -Midnight shifts: 1/6/25, needed 7.6 and only had 6.25. Census was 114. 1/8/25, needed 7.93 and only had 5.75. Census was 119. 1/11/25, needed 7.67 and only had 5.44. Census was 115.	P 5520		

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P 5520	Continued from page 11 1/13/25, needed 7.53, and only had 4.5. Census was 113. Interview on 1/24/25 at 10:36 a.m. the Nursing Home Administrator confirmed that the facility failed to provide the State required minimum of one Nurse Aide (NA) per 10 residents on the daylight shift for six out of 21 days (1/3/25, 1/5/25, 1/6/25, 1/9/25, 1/17/25, and 1/18/25), and failed to provide the State required minimum of one NA per 11 residents on two out of 21 evening shifts (1/10/25, and 1/17/25), and failed to provide the State required minimum of one NA per 15 residents on four of 21 midnight shifts (1/6/25, 1/8/25, 1/11/25, and 1/13/25).	P 5520		



Certified End Page

CRANBERRY PLACE

STATE LICENSE NUMBER: 381602

SURVEY EXIT DATE: 01/24/2025

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


Jeanne Parisi
Deputy Secretary for Quality Assurance


Debra L. Bogen, MD, FAAP
Secretary of Health



**Pennsylvania
Department of Health**

THIS IS A CERTIFICATION PAGE

PLEASE DO NOT DETACH

THIS PAGE IS NOW PART OF THIS SURVEY