

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395861	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/15/2025
--	---	---	--

NAME OF PROVIDER OR SUPPLIER: HRH TRANSITIONAL CARE UNIT (A D/B/A ENTITY OF HRHS)	STREET ADDRESS, CITY, STATE, ZIP CODE: 1648 HUNTINGDON PIKE MEADOWBROOK, PA 19046
STATE LICENSE NUMBER: 083902	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0000	INITIAL COMMENT	F 0000		
F 0640 SS=C	Based on a Medicare Recertification survey, State Licensure survey and a Civil Rights Compliance survey, completed on January 15, 2025, it was determined that HRH Transitional Care Unit had a deficiency that has the potential for minimal harm to residents as related to the 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 0640		

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395861	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/15/2025
--	---	---	--

NAME OF PROVIDER OR SUPPLIER: HRH TRANSITIONAL CARE UNIT (A D/B/A ENTITY OF HRHS) STATE LICENSE NUMBER: 083902	STREET ADDRESS, CITY, STATE, ZIP CODE: 1648 HUNTINGDON PIKE MEADOWBROOK, PA 19046
--	---

(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 0640 SS=C	<p>Continued from page 1</p> <p>483.20(f)(1)-(4) Encoding/Transmitting Resident Assessments</p> <p>§483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility:</p> <ul style="list-style-type: none"> (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. <p>§483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State.</p> <p>§483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following:</p> <ul style="list-style-type: none"> (i) Admission assessment. 	F 0640	<p>The assessment for the two of two residents who had been discharged from the Facility have been completed and transmitted. (Residents 1, 3)</p> <p>Holy Redeemer TCU facility will assess all records in the system to assure all residents data is now completed and electronically transmitted to the Centers for Medicare & Medicaid Services (CMS) immediately.</p> <p>The facility RNAC will electronically transmit encoded Minimum Data Set (MDS) data to the Centers for Medicare & Medicaid Services (CMS) within 14 days after residents are discharged from the facility. The nurse manager and NHA or their designee will monitor MDS transmissions weekly to assure compliance. We complete this audit by running the MDS in progress list from PCC weekly to assure they are all up to date and submitted. We will also run all admissions and discharges list from the EHR and</p>	<p>Completion Date: 02/07/2025 Status: APPROVED Date: 01/22/2025</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395861	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/15/2025
NAME OF PROVIDER OR SUPPLIER: HRH TRANSITIONAL CARE UNIT (A D/B/A ENTITY OF HRHS)		STREET ADDRESS, CITY, STATE, ZIP CODE: 1648 HUNTINGDON PIKE MEADOWBROOK, PA 19046		
STATE LICENSE NUMBER: 083902				
(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 0640 SS=C	Continued from page 2 (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced by:	F 0640	reconcile the two reports to assure no one is missed each week. The RNAC and the Unit Manager have been in serviced on the requirement and how to comply. MDS transmission compliance reports will be added to QAPI quarterly for next 6 months.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395861	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/15/2025	
NAME OF PROVIDER OR SUPPLIER: HRH TRANSITIONAL CARE UNIT (A D/B/A ENTITY OF HRHS) STATE LICENSE NUMBER: 083902		STREET ADDRESS, CITY, STATE, ZIP CODE: 1648 HUNTINGDON PIKE MEADOWBROOK, PA 19046		
(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 0640 SS=C	Continued from page 3 Based on clinical record review and staff interview, it was determined that the facility failed to electronically transmit encoded Minimum Data Set (MDS) data to the Centers for Medicare & Medicaid Services (CMS) within 14 days after the facility completed the resident assessment for two of two residents who had been discharged from the facility. (Residents 1, 3) Findings include: Clinical record review revealed that a discharge MDS assessment was completed on December 4, 2024, for Resident 1, however the record reflected that the MDS had not been exported as of January 15, 2025. Clinical record review revealed that a discharge MDS assessment was completed on December 11, 2024, for Resident 3, however, the record reflected that the MDS had not been exported as of January 15, 2025.	F 0640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395861	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/15/2025	
NAME OF PROVIDER OR SUPPLIER: HRH TRANSITIONAL CARE UNIT (A D/B/A ENTITY OF HRHS) STATE LICENSE NUMBER: 083902		STREET ADDRESS, CITY, STATE, ZIP CODE: 1648 HUNTINGDON PIKE MEADOWBROOK, PA 19046		
(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 0640 SS=C	Continued from page 4 In an interview on January 15, 2025, at 9:56 a.m., RN1 stated that the discharge MDS assessments had not been exported and transmitted to the CMS system in a timely manner.	F 0640		



Certified End Page

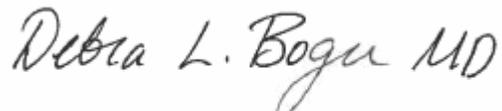
HRH TRANSITIONAL CARE UNIT (A D/B/A ENTITY OF HRHS)

STATE LICENSE NUMBER: 083902

SURVEY EXIT DATE: 01/15/2025

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