STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395882	A. BLDG: 00 B. WING:	12/26/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
LONGWOOD AT OAKMONT STATE LICENSE NUMBER: **017202**	**500 ROUTE 909** **VERONA, PA 15147**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0000	INITIAL COMMENT Based on an Abbreviated Survey in response to a complaint, completed on December 26, 2024, it was determined that Longwood at Oakmont was not in compliance with the following requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities and the 28 Pa. Code, Commonwealth of Pennsylvania Long Term Care Licensure Regulations.	F 0000		
F 0600 SS=D		F 0600		

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 0600 SS=D	Continued from page 1 483.12(a)(1) Free from Abuse and Neglect §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by:	F 0600	The Executive Director of Healthcare Services and Director of Nursing investigated this incident on the evening of the incident. Employee E1 acknowledged that he placed the bandage on Resident R1s arm and forgot to tell the nurse. The Director of Nursing reviewed the incident with employee E1 on 12/17/24 and shared that he operated outside of his scope of practice and further failed to report the incident to the nurse. Education and corrective action was issued to Employee E1 on 12/23/24 to ensure the employee understood his job description and the importance of giving full report to his nurse and the oncoming shift. Resident R1's right elbow is healing properly and there were no negative outcomes as a result of this incident. Employee E1 was educated on 12/17/24 on appropriate reporting and treatment protocols when a resident health incident occurs. All residents have the potential to be affected by this aberrant practice. The DON/designees will perform a one-time audit of front line team	Completion Date: **02/03/2025** Status: **APPROVED** Date: **01/03/2025**

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F 0600 SS=D	Continued from page 2	F 0600	members to ensure they have been educated on timely reporting of incidents involving potential abuse or neglect. The Director of Nursing/designees will observe resident care one time daily five days per week for six weeks. Results of the audits will be presented to the QAPI team for any negative trends and follow up recommendations.	

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F 0600 SS=D	Continued from page 3 Based on review of facility policy, clinical record review, and staff interviews, it was determined that the facility failed to ensure that residents were free from neglect for one of four residents reviewed (Resident R1). Finding include: Review of facility policy "Skilled Nursing - Abuse" dated 11/5/24, indicated neglect is the failure of the community, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. Review of the clinical record indicated Resident R1 was admitted to the facility on 3/14/23. Review of Resident R1's Minimum Data Set (MDS - a periodic assessment of care needs) dated 10/13/24, indicated diagnoses of dementia (a group of symptoms that affects memory, thinking and interferes with daily life), muscle weakness, and	F 0600		

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F 0600 SS=D	Continued from page 4 repeated falls. Review of Resident R1's care plan dated 10/22/24, indicated the resident has potential for impairment to skin integrity related to fragile skin, impaired mobility, bladder incontinence and fall history with history of skin tears. Review of a physician order dated 12/17/24, indicated to cleanse right forearm skin tear and surrounding area with NSS (normal sterile saline), steri-strips applied, cover with Tegaderm foam border dressing, change every 7 days until healed. Review of a facility Incident Report completed by Licensed Practical Nurse Employee E3 stated, "This writer was made aware of a 2 x 2.5 cm (centimeter) bruise on occipital bone (back of head) during resident dinner. Bruise was purple in color with no open areas and resident neurologically at baseline. This writer informed Charge Nurse and physician and also called the resident's daughter. When speaking with the daughter she alerted me her father	F 0600		

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F 0600 SS=D	Continued from page 5 had a skin tear near his right elbow and informed Nurse Aide (NA) Employee E1 around 11 a.m. on 12/16/24. NA Employee E1 came back with Tegaderm and informed her the nurse was aware and dressed wound without cleansing it. The daughter said she was skeptical on why the wound wasn't cleansed first but figured he knew what he was doing since the nurse was aware. After assessing the wound with the Charge Nurse the skin wasn't approximated (clean edges that fit neatly together), had moderate bleeding, and was 6 cm x 1 cm near the end of the wound." During an interview on 12/26/24, at 12:50 p.m. the Director of Nursing (DON) stated, "I'm aware of the situation but I didn't investigate it as neglect. We performed a Corrective Action Plan for NA Employee E1 and obtained a statement from him for that." Review of NA Employee E1's statement dated 12/17/24, stated, "On December 16, 2024 I was in the hallway when Resident R1's daughter came to	F 0600		

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F 0600 SS=D	Continued from page 6 me and said his arm was bleeding and to look at it. When I came to the room I saw blood on his right arm. His daughter said what do we do. I said let me find the nurse and I couldn't find the nurse. That's when I panicked and got a clear bandage from the supply room and put it on his arm. The nurse was gone half the shift and I honestly forgot to tell her." During an interview on 12/26/24, at 12:50 p.m. the DON confirmed that the facility failed to ensure that residents were free from neglect for one of four residents as required. 28. Pa Code 201.14(a) Responsibility of licensee. 28. Pa Code 201.18(b)(1)(e)(1) Management. 28. Pa. Code 211.12(d)(1)(5) Nursing services.	F 0600		
F 0607 SS=D		F 0607		

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F 0607 SS=D	Continued from page 7 483.12(b)(1)-(5)(ii)(iii) Develop/Implement Abuse/Neglect Policies §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, §483.12(b)(4) Establish coordination with the QAPI program required under §483.75. §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements. §483.12(b)(5)(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act. §483.12(b)(5)(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act.	F 0607	1. The incident that occurred with resident #R1 was reported to the Pennsylvania Department of Health and Adult Protective Services on 12/26/2024. A thorough review of all incidents current resident records will be conducted to identify any instances where the failure to report incidents, changes in condition, or abuse/neglect was noted. This review will cover the past 30 days from the date of the citation. 2. All relevant incidents, including changes in a resident's condition, suspected abuse, neglect, or other critical information that should have been reported, will be documented and immediately reported to the appropriate agencies as per state regulations. Staff will also ensure that these incidents are fully documented in resident records. The Senior Director of Clinical Services will re-educate the director of nursing and executive director of health services on the abuse and neglect policy to ensure that instances that may be considered	Completion Date: **02/03/2025** Status: **APPROVED** Date: **01/03/2025**

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F 0607 SS=D	Continued from page 8 This REQUIREMENT is not met as evidenced by:	F 0607	abuse or neglect are reported timely as appropriate to the designated agencies. The Director of Nursing and Executive Director of Health Services or their designees, will re-educate team members by the compliance date on the need to report all incidents where there is a need for nursing intervention to ensure if there is any evidence of potential abuse or neglect that it gets reported immediately to nursing supervisors and addressed immediately with the abuse reporting compliance team. The Director of Nursing/designee will audit incidents and accidents weekly for six weeks to ensure a thorough investigation has occurred and if necessary appropriate reporting has been submitted through PA Department of Health's Event Reporting System. The results of these audits will be shared with the Quality Assurance Performance Improvement Committee for review of trends that may require further action.	

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F 0607 SS=D	Continued from page 9 Based on review of facility documents, facility policy, clinical records, and staff interviews, it was determined that the facility failed to implement written policies and procedures to ensure a complete and thorough investigation of an allegation of neglect for one of four residents (Resident R1). Findings include: Review of facility policy "Skilled Nursing - Abuse" dated 11/5/24, indicated neglect is the failure of the community, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. Reports of abuse (mistreatment, neglect, or abuse, including injuries of unknown source, exploitation and misappropriation of property) are promptly and thoroughly investigated and are reported per Federal and State Law. Review of the clinical record indicated Resident R1 was admitted to the facility on 3/14/23.	F 0607		

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F 0607 SS=D	Continued from page 10 Review of Resident R1's Minimum Data Set (MDS - a periodic assessment of care needs) dated 10/13/24, indicated diagnoses of dementia (a group of symptoms that affects memory, thinking and interferes with daily life), muscle weakness, and repeated falls. Review of Resident R1's care plan dated 10/22/24, indicated the resident has potential for impairment to skin integrity related to fragile skin, impaired mobility, bladder incontinence and fall history with history of skin tears. Review of a physician order dated 12/17/24, indicated to cleanse right forearm skin tear and surrounding area with NSS (normal sterile saline), steri-strips applied, cover with Tegaderm foam border dressing, change every 7 days until healed. Review of a facility Incident Report completed by Licensed Practical Nurse Employee E3 stated, "This writer was made aware of a 2 x 2.5 cm (centimeter)	F 0607		

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F 0607 SS=D	Continued from page 11 bruise on occipital bone (back of head) during resident dinner. Bruise was purple in color with no open areas and resident neurologically at baseline. This writer informed Charge Nurse and physician and also called the resident's daughter. When speaking with the daughter she alerted me her father had a skin tear near his right elbow and informed Nurse Aide (NA) Employee E1 around 11 a.m. on 12/16/24. NA Employee E1 came back with Tegaderm and informed her the nurse was aware and dressed wound without cleansing it. The daughter said she was skeptical on why the wound wasn't cleansed first but figured he knew what he was doing since the nurse was aware. After assessing the wound with the Charge Nurse the skin wasn't approximated (clean edges that fit neatly together), had moderate bleeding, and was 6 cm x 1 cm near the end of the wound." During an interview on 12/26/24, at 12:50 p.m. the Director of Nursing (DON) stated, "I'm aware of the situation but I didn't investigate or report it as neglect. We performed a Corrective Action Plan for	F 0607		

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F 0607 SS=D	Continued from page 12 NA Employee E1 and obtained a statement from him for that." Review of NA Employee E1's statement dated 12/17/24, stated, "On December 16, 2024 I was in the hallway when Resident R1's daughter came to me and said his arm was bleeding and to look at it. When I came to the room I saw blood on his right arm. His daughter said what do we do. I said let me find the nurse and I couldn't find the nurse. That's when I panicked and got a clear bandage from the supply room and put it on his arm. The nurse was gone half the shift and I honestly forgot to tell her." During an interview on 12/26/24, at 12:50 p.m. the DON confirmed that the facility failed to implement written policies and procedures to ensure a complete and thorough investigation of an allegation of neglect for one of four residents as required. 28 Pa. Code 201.14(a) Responsibility of licensee. 28 Pa. Code 201.18(e)(1) Management.	F 0607		

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F 0609 SS=D		F 0609		

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F 0609 SS=D	Continued from page 14 483.12(b)(5)(i)(A)(B)(c)(1)(4) Reporting of Alleged Violations §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by:	F 0609	The incident that occurred with resident #R1 was reported to the Pennsylvania Department of Health and Adult Protective Services on 12/26/2024. A thorough review of all incidents current resident records will be conducted to identify any instances where the failure to report incidents, changes in condition, or abuse/neglect was noted. This review will cover the past 30 days from the date of the citation. 2. All relevant incidents, including changes in a resident's condition, suspected abuse, neglect, or other critical information that should have been reported, will be documented and immediately reported to the appropriate agencies as per state regulations. Staff will also ensure that these incidents are fully documented in resident records. The Senior Director of Clinical Services will re-educate the director of nursing and executive director of health services on the abuse and neglect policy to ensure that instances that may be considered	Completion Date: **02/03/2025** Status: **APPROVED** Date: **01/03/2025**

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F 0609 SS=D	Continued from page 15	F 0609	abuse or neglect are reported timely as appropriate to the designated agencies. The Director of Nursing and Executive Director of Health Services or their designees, will re-educate team members by the compliance date on the need to report all incidents where there is a need for nursing intervention to ensure if there is any evidence of potential abuse or neglect that it gets reported immediately to nursing supervisors and addressed immediately with the abuse reporting compliance team. The Director of Nursing/designee will audit abuse and neglect incidents submitted through the PA Department of Health's Event Reporting System for timeliness of investigation and reporting for six weeks. The results of these audits will be shared with the Quality Assurance Performance Improvement Committee for review of trends that may require further action.	

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	395882	A. BLDG: __00_____ B. WING: _____	12/26/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
LONGWOOD AT OAKMONT STATE LICENSE NUMBER: **017202**	**500 ROUTE 909** **VERONA, PA 15147**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0609 SS=D	Continued from page 16 Based on review of facility policy, clinical record review, reports submitted to the State, and staff interview, it was determined that the facility failed to report an allegation of neglect in the required timeframe one of four residents (Resident R1). Findings include: Review of facility policy "Skilled Nursing - Abuse" dated 11/5/24, indicated neglect is the failure of the community, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. Reports of abuse (mistreatment, neglect, or abuse, including injuries of unknown source, exploitation and misappropriation of property) are promptly and thoroughly investigated and are reported per Federal and State Law. Review of the clinical record indicated Resident R1 was admitted to the facility on 3/14/23.	F 0609		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0609 SS=D	Continued from page 17 Review of Resident R1's Minimum Data Set (MDS - a periodic assessment of care needs) dated 10/13/24, indicated diagnoses of dementia (a group of symptoms that affects memory, thinking and interferes with daily life), muscle weakness, and repeated falls. Review of Resident R1's care plan dated 10/22/24, indicated the resident has potential for impairment to skin integrity related to fragile skin, impaired mobility, bladder incontinence and fall history with history of skin tears. Review of a physician order dated 12/17/24, indicated to cleanse right forearm skin tear and surrounding area with NSS (normal sterile saline), steri-strips applied, cover with Tegaderm foam border dressing, change every 7 days until healed. Review of a facility Incident Report completed by Licensed Practical Nurse Employee E3 stated, "This writer was made aware of a 2 x 2.5 cm (centimeter) bruise on occipital bone (back of head) during	F 0609		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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LONGWOOD AT OAKMONT STATE LICENSE NUMBER: **017202**	**500 ROUTE 909 VERONA, PA 15147**

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F 0609 SS=D	Continued from page 18 resident dinner. Bruise was purple in color with no open areas and resident neurologically at baseline. This writer informed Charge Nurse and physician and also called the resident's daughter. When speaking with the daughter she alerted me her father had a skin tear near his right elbow and informed Nurse Aide (NA) Employee E1 around 11 a.m. on 12/16/24. NA Employee E1 came back with Tegaderm and informed her the nurse was aware and dressed wound without cleansing it. The daughter said she was skeptical on why the wound wasn't cleansed first but figured he knew what he was doing since the nurse was aware. After assessing the wound with the Charge Nurse the skin wasn't approximated (clean edges that fit neatly together), had moderate bleeding, and was 6 cm x 1 cm near the end of the wound." During an interview on 12/26/24, at 12:50 p.m. the Director of Nursing (DON) stated, "I'm aware of the situation but I didn't investigate or report it as neglect. We performed a Corrective Action Plan for NA Employee E1 and obtained a statement from	F 0609		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0609 SS=D	Continued from page 19 him for that." Review of NA Employee E1's statement dated 12/17/24, stated, "On December 16, 2024 I was in the hallway when Resident R1's daughter came to me and said his arm was bleeding and to look at it. When I came to the room I saw blood on his right arm. His daughter said what do we do. I said let me find the nurse and I couldn't find the nurse. That's when I panicked and got a clear bandage from the supply room and put it on his arm. The nurse was gone half the shift and I honestly forgot to tell her." During an interview on 12/26/24, at 12:50 p.m. the DON confirmed that the facility failed to report an allegation of neglect in the required timeframe one of four residents as required. 28 Pa. Code 201.14(a)(c.)(e.) Responsibility of licensee. 28 Pa. Code 201.18(b)(1)(3)(e)(1) Management. 28 Pa. Code 201.20(b) Staff development. 28 Pa. Code 211.10(c.)(d) Resident care policies.	F 0609		

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F 0610 SS=D		F 0610		

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F 0610 SS=D	Continued from page 21 483.12(c)(2)-(4) Investigate/Prevent/Correct Alleged Violation §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by:	F 0610	Incident with R1 was investigated and reported to the Department of Health of 12/26/24. The resident had sustained a skin tear and team member became aware of the skin tear when daughter reported it during her visit on 12/16/24. The Executive Director of Health Services confirmed that the C NA did apply a tegaderm dressing and failed to report it to the nurse. A PB22 was completed and the allegation of neglect was substantiated and addressed internally through corrective action. The skin tear was appropriately treated on 12/16/24 by the RN charge nurse and documented accordingly. The wound is healing properly. An audit of incidents and accidents from the time of this incident will be reviewed to ensure that they have been investigated properly and any potential allegations of abuse or neglect have been properly reported. Any identified issues will be reported at the time of discovery.	Completion Date: **02/03/2025** Status: **APPROVED** Date: **01/03/2025**

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F 0610 SS=D	Continued from page 22	F 0610	The Director of Nursing and NHA were reeducated by the Senior Clinical Services Director on January 3, 2025 on the policy to respond to allegations of abuse, neglect, exploitation, or mistreatment and any alleged violations have are thoroughly investigated with evidence of interventions to prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. Audits will be completed monthly times 3 of any abuse allegations received by the facility to ensure the investigation is thorough and allegations are reported to DOH if appropriate by NHA or designee. Results will be brought to QAPI to	

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F 0610 SS=D	Continued from page 23	F 0610	determine if further auditing is necessary.	

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F 0610 SS=D	Continued from page 24 Based on review of facility documents, facility policy, clinical records, and staff interview, it was determined that the facility failed to conduct a thorough investigation of an allegation of neglect for one of four residents (Resident R1). Findings include: Review of facility policy "Skilled Nursing - Abuse" dated 11/5/24, indicated neglect is the failure of the community, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. Reports of abuse (mistreatment, neglect, or abuse, including injuries of unknown source, exploitation and misappropriation of property) are promptly and thoroughly investigated and are reported per Federal and State Law. Review of the clinical record indicated Resident R1 was admitted to the facility on 3/14/23.	F 0610		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0610 SS=D	Continued from page 25 Review of Resident R1's Minimum Data Set (MDS - a periodic assessment of care needs) dated 10/13/24, indicated diagnoses of dementia (a group of symptoms that affects memory, thinking and interferes with daily life), muscle weakness, and repeated falls. Review of Resident R1's care plan dated 10/22/24, indicated the resident has potential for impairment to skin integrity related to fragile skin, impaired mobility, bladder incontinence and fall history with history of skin tears. Review of a physician order dated 12/17/24, indicated to cleanse right forearm skin tear and surrounding area with NSS (normal sterile saline), steri-strips applied, cover with Tegaderm foam border dressing, change every 7 days until healed. Review of a facility Incident Report completed by Licensed Practical Nurse Employee E3 stated, "This writer was made aware of a 2 x 2.5 cm (centimeter) bruise on occipital bone (back of head) during	F 0610		

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F 0610 SS=D	Continued from page 26 resident dinner. Bruise was purple in color with no open areas and resident neurologically at baseline. This writer informed Charge Nurse and physician and also called the resident's daughter. When speaking with the daughter she alerted me her father had a skin tear near his right elbow and informed Nurse Aide (NA) Employee E1 around 11 a.m. on 12/16/24. NA Employee E1 came back with Tegaderm and informed her the nurse was aware and dressed wound without cleansing it. The daughter said she was skeptical on why the wound wasn't cleansed first but figured he knew what he was doing since the nurse was aware. After assessing the wound with the Charge Nurse the skin wasn't approximated (clean edges that fit neatly together), had moderate bleeding, and was 6 cm x 1 cm near the end of the wound." During an interview on 12/26/24, at 12:50 p.m. the Director of Nursing (DON) stated, "I'm aware of the situation but I didn't investigate or report it as neglect. We performed a Corrective Action Plan for NA Employee E1 and obtained a statement from	F 0610		

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F 0610 SS=D	Continued from page 27 him for that." Review of NA Employee E1's statement dated 12/17/24, stated, "On December 16, 2024 I was in the hallway when Resident R1's daughter came to me and said his arm was bleeding and to look at it. When I came to the room I saw blood on his right arm. His daughter said what do we do. I said let me find the nurse and I couldn't find the nurse. That's when I panicked and got a clear bandage from the supply room and put it on his arm. The nurse was gone half the shift and I honestly forgot to tell her." During an interview on 12/26/24, at 12:50 p.m. the DON confirmed that the facility failed to conduct a thorough investigation of an allegation of neglect for one of four residents as required. 28 Pa Code: 201.18 (e)(1)(2) Management. 28 Pa Code: 201.29 (a)(c)(d) Resident Rights. 28 Pa Code: 211.12 (a)(c)(d)(1)(3)(5) Nursing services.	F 0610		

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F 0880 SS=E		F 0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0880 SS=E	Continued from page 29 483.80(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	All residents who were experiencing diarrhea or vomiting symptoms as of 12/26/2024 were reviewed and any missing orders were added to the resident's medical record. Appropriate isolation signage was placed to the door of any resident with orders for isolation if signage was found to be missing. setup for all residents who had an isolation setup ensured to have an order for isolation and contact isolation signs in place. Any resident who has illness or symptoms that require isolation has the potential to be affected by this alleged aberrant practice. Team members will be educated by the Director of Nursing/ designee before the compliance date on the appropriate isolation protocols and setup to include physician orders for the isolation and isolation precaution signage at the resident's door while the isolation is in place. An isolation checklist will be developed to help guide the nursing team any time a resident is placed in isolation precaution.	Completion Date: **02/03/2025** Status: **APPROVED** Date: **01/03/2025**

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F 0880 SS=E	Continued from page 30 (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 Director of Nursing/designee will complete audits weekly audits for six weeks to ensure all isolation precaution protocols including physician orders and appropriate signage are in place for residents who are ordered isolation. Audits will be reviewed by QAPI committee until such time consistent substantial compliance has been achieved as determined by the QAPI committee.	

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F 0880 SS=E	Continued from page 31	F 0880		

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F 0880 SS=E	Continued from page 32 Based on observation, clinical record review, and resident and staff interviews, it was determined that the facility failed to implement appropriate transmission-based precautions for 11 of 16 residents reviewed (Residents R1, R2, R3, R4, R5, R6, R7, R8, R9, R10, and R11). Findings include: Review of facility policy "Infection Control-Infection Prevention and Control Program" dated 11/5/24, indicated a resident with an infection or communicable disease shall be placed on transmission-based precautions as recommended by current CDC (Centers for Disease Control and Prevention) guidelines. Review of facility policy "Norovirus Prevention and Control" dated 11/5/24, indicated this facility will implement strict infection control measures to prevent the transmission of norovirus infection. During outbreaks, residents with norovirus gastroenteritis will be placed on Contact Precautions	F 0880		

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NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
LONGWOOD AT OAKMONT STATE LICENSE NUMBER: **017202**	**500 ROUTE 909** **VERONA, PA 15147**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0880 SS=E	Continued from page 33 for a minimum of 48 hours after the resolution of symptoms. Review of the CDC Guidelines indicated Contact Precautions are measures that are intended to prevention transmission of infectious agents which are spread by direct or indirect contact with the resident or the resident's environment. Contact Precautions require the use of gown and gloves on every entry into a resident's room, regardless of the level of care being provided to the resident. During an interview on 12/26/24, the Director of Nursing (DON) stated that the facility had several residents with gastrointestinal illness symptoms such as nausea, vomiting, and diarrhea, but at the time, no resident stool sample had come back positive for Norovirus. Review of the facility's "Outbreak Line List" on 12/26/24, indicated 16 residents had reported gastrointestinal illness symptoms and were being treated as positive for Norovirus.	F 0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395882	A. BLDG: __00_____ B. WING: _____	12/26/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
LONGWOOD AT OAKMONT STATE LICENSE NUMBER: **017202**	**500 ROUTE 909** **VERONA, PA 15147**

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F 0880 SS=E	Continued from page 34 Review of the facility's "Outbreak Line List" revealed the following: Resident R1 had symptoms of diarrhea starting on 12/22/24. Review of a physician order dated 12/22/24, indicated Resident R1 was placed on Contact Precautions for Norovirus until no further N/V/D (nausea/vomiting/diarrhea) for 48 hours. During an observation on 12/26/24, at 12:10 p.m. no sign was present outside of Resident R1's room indicating that the resident was ordered Contact Precautions. Resident R2 had symptoms of diarrhea starting on 12/20/24. Review of Resident R2's physician orders failed to include an order for Contact Precautions.	F 0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395882	A. BLDG: __00_____ B. WING: _____	12/26/2024

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F 0880 SS=E	Continued from page 35 Resident R3 had symptoms of diarrhea starting on 12/21/24. Review of Resident R3's physician orders failed to include an order for Contact Precautions. Resident R4 had symptoms of diarrhea and vomiting starting on 12/23/24. Review of Resident R4's physician orders failed to include an order for Contact Precautions. Resident R5 had symptoms of diarrhea and vomiting starting on 12/23/24. Review of a physician order dated 12/23/24, indicated Resident R5 was on Contact isolation precautions for Norovirus. During an observation on 12/26/24, at 11:51 a.m. no signage was present outside of Resident R5's room indicating that the resident was ordered Contact Precautions.	F 0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0880 SS=E	Continued from page 36 Resident R6 had symptoms of diarrhea and vomiting starting on 12/23/24. Review of Resident R6's physician orders failed to include an order for Contact Precautions. Resident R7 had symptoms of diarrhea and vomiting starting on 12/23/24. Review of Resident R7's physician orders failed to include an order for Contact Precautions. Resident R8 had symptoms of diarrhea and vomiting starting on 12/22/24. Review of a physician order dated 12/22/24, indicated Resident R8 was on Contact precautions for Norovirus until no further N/V/D for 48 hours. During an observation on 12/26/24, at 12:08 p.m. no signage was present outside of Resident R8's room indicating that the resident was ordered	F 0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0880 SS=E	Continued from page 37 Contact Precautions. Resident R9 had symptoms of diarrhea and vomiting starting on 12/22/24. Review of Resident R9's physician orders failed to include an order for Contact Precautions. Resident R10 had symptoms of diarrhea and vomiting starting on 12/22/24. Review of a physician order dated 12/22/24, indicated Resident R10 was on Contact Precautions for Norovirus until no N/V/D for 48 hours. During an observation on 12/26/24, at 12:09 p.m. no signage was present outside of Resident R10's room indicating that the resident was ordered Contact Precautions. Resident R11 had symptoms of diarrhea starting on 12/22/24.	F 0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0880 SS=E	Continued from page 38 Review of a physician order dated 12/22/24, indicated Resident R11 was on Isolation Precautions for Norovirus until no N/V/D for 48 hours. During an observation on 12/26/24, at 12:10 p.m. no signage was present outside of Resident R11's room indicating that the resident was ordered Contact Precautions. During an interview on 12/26/24, at 11:51 a.m. Registered Nurse Employee E2 stated, "We get in report which residents are in isolation precautions and why. The residents on this unit seem to have symptoms for only a few hours and then they are done. The rooms should have a sign up indicating that they are on isolation precautions. The Nurse Practitioner will write an order and then that order gets entered into the electronic medical record and the corresponding isolation sign gets put on the door of the resident room." During an interview on 12/26/24, at 12:21 p.m. the	F 0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0880 SS=E	Continued from page 39 DON stated, "Residents in isolation precautions should have signs on their doors and an order in the computer. I think the isolation only lasts for 48 hours, some of the residents on the line list are already out of isolation." During an interview on 12/26/24, at 12:0 p.m. the DON stated, "Residents who don't have isolation orders are having them entered into the computer now and residents who don't have isolation signs on their doors are having them placed right now." During an interview on 12/26/24, at 12:50 p.m. the DON confirmed that the facility failed to implement appropriate transmission-based precautions for 11 of 16 residents as required. 28 Pa. Code 201.14(a) Responsibility of licensee. 28 Pa. Code 201.18(b)(1)(3)(d)(e)(1) Management. 28 Pa. Code 211.10(d) Resident care policies. 28 Pa. Code 211.12(d)(1)(5) Nursing services.	F 0880		

Certified End Page

LONGWOOD AT OAKMONT

STATE LICENSE NUMBER: 017202

SURVEY EXIT DATE: 12/26/2024

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

Jeanne Parisi
Deputy Secretary for Quality Assurance

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

Pennsylvania
Department of Health

THIS IS A CERTIFICATION PAGE

PLEASE DO NOT DETACH

THIS PAGE IS NOW PART OF THIS SURVEY