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:	01/09/2025

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 a Medicare/Medicaid Recertification survey, State Licensure survey, Civil Rights Compliance, and an Abbreviated survey in response to a complaint completed on 1/9/25, 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 and the 28 Pa. Code, Commonwealth of Pennsylvania Long Term Care Licensure Regulations.	F 0000		
F 0622 SS=D		F 0622		

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 0622 SS=D	Continued from page 1 483.15(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	The facility submits this plan of correction under procedures established by the Department of Health in order to comply with the Department's directive to change conditions which the Department alleges are deficient under State and Federal regulations relating to long term care. This plan of correction should not be construed as either a waiver of the Facility's right to appeal and to challenge the accuracy or severity of the alleged deficiencies or an admission of past or ongoing violations of State and Federal regulatory requirements. Any resident transferred or discharged to the hospital after 1/9/2025 was audited to ensure all required documentation was transferred with the transferred resident. R52 was not affected by the deficient practice of not providing documentation at the time of transfer to the hospital. All discharged residents had the potential to be affected by the deficient practice,	Completion Date: **02/25/2025** Status: **APPROVED** Date: **01/21/2025**

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F 0622 SS=D	Continued from page 2 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	however, there were no known negative outcomes. The DON/ Designee will educate nursing staff on including the correct documentation of resident care in the transfer process for the accepting healthcare provider. The DON/Designee will conduct daily audits for four weeks to ensure resident documentation regarding their plan of care is included in the transfer process of all residents who are transferred to another healthcare provider for further care. The results of audits will be submitted to the QAPI committee to review for any trends that require further recommendation follow up.	

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F 0622 SS=D	Continued from page 3 (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=D	Continued from page 4 Based on clinical record review and staff interview, it was determined that the facility failed to make certain that the necessary resident information was communicated to the receiving health care provider for one out of three residents sampled with facility-initiated transfer (Residents R52). Findings include: Review of Resident R52's admission record indicated she was originally admitted on 10/25/23, with diagnoses that included surgical aftercare, muscle weakness and venous insufficiency. Review of Resident R52's clinical record revealed that the resident was transferred to the hospital on 10/13/24, and did not return to the facility. Review of Resident R52's clinical record revealed no documented evidence that the facility had communicated specific information to the receiving health care provider for the residents transferred and expected to return, which included the resident's	F 0622		

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F 0622 SS=D	Continued from page 5 care plan goals, advanced directive information, specific instructions for ongoing care, resident representative information, and all information necessary to meet the residents specific needs at the receiving facility. During an interview on 1/9/25, at 10:30 a.m. the Director of Nursing (DON) confirmed that the facility failed to provide the necessary information for Resident R52. 28 Pa. Code 201.29(a)(c)(3)(2) Resident rights.	F 0622		
F 0623 SS=D		F 0623		

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F 0623 SS=D	Continued from page 6 483.15(c)(3)-(6)(8) Notice Requirements Before Transfer/Discharge §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)	F 0623	The administrator sent the facility initiated discharge report for the month of December, 2024 to the State Long Term Care Ombudsman to the LTC-Ombudsman@pa.gov on January 10, 2025. All discharged residents from Longwood had the potential to be affected by the deficient practice. There were no known negative outcomes. The administrator and social services director were re-educated by the email guidance given by the office of the long term care ombudsman on January 10, 2025. The Social Services Director or Administrator/designee will submit the discharge report to the state long term care ombudsman before the last day of the following month every month going forward. The reports will be submitted at the next two Quality Assurance Committee meetings to ensure compliance. Any identified non-compliance will be addressed at the time of discovery and reviewed for further recommendations.	Completion Date: **02/25/2025** Status: **APPROVED** Date: **01/21/2025**

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F 0623 SS=D	Continued from page 7 (1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and	F 0623		

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F 0623 SS=D	Continued from page 8 (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(k). This REQUIREMENT is not met as evidenced by:	F 0623		

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F 0623 SS=D	Continued from page 9 Based on clinical record review and staff interview, it was determined that the facility failed to provide a transfer notice to a representative of the Office of the Long-Term Care Ombudsman Division for two out of three residents (Residents R39, R52). Findings include: Review of Resident R39's admission record indicated he was originally admitted on 2/9/23, with diagnoses that included dementia(decline in mental abilities that affects thinking, memory, and reasoning), diabetes mellitus and hyperlipidemia. Review of Resident R39's clinical record revealed that the resident was transferred to the hospital on 9/9/24, and returned to the facility on 9/11/24. Review of Resident R39's clinical record indicated the facility failed to include documented evidence that the facility provided a written transportation notification to the Office of the Long-Term Care Ombudsman for the hospitalization on 9/9/24.	F 0623		

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F 0623 SS=D	Continued from page 10 Review of Resident R52's admission record indicated she was originally admitted on 10/25/23, with diagnoses that included surgical aftercare, muscle weakness and venous insufficiency. Review of the clinical record indicated Resident R52 was transferred to hospital on 10/13/24, and did not return to the facility. Review of Resident R52's clinical record indicated the facility failed to include documented evidence that the facility provided a written transportation notification to the Office of the Long-Term Care Ombudsman for the hospitalization on 10/13/24. During an interview on 1/9/25, at 10:30 a.m. the Director of Nursing (DON) confirmed the facility failed to provide a transfer notice to a representative of the Office of the Long-Term Care Ombudsman Division for two out of three residents (Residents R39, R52). 28 Pa. Code 201.29(a)(c)(3)(2) Resident rights.	F 0623		

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F 0625 SS=D	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	The bedhold policy is given to all residents upon admission. Residents 39 and 52 were not given a copy of the bed hold policy at the time of their transfer out to the hospital. There were no identified negative outcomes from the deficient practice of the resident/representative not receiving a copy of the bedhold policy at the time of transfer/discharge. The Director of Nursing/designee will educate team members on the need to provide the written bed hold notice before a resident/patient is transferred out of the facility. The Director of Nursing or designee will conduct audits on all discharged residents/residents daily for 4 weeks to ensure the Bed Hold Policy agreement is included with the transfer process and the resident and or the resident's family are aware of the bed hold process. The results of the audits will be presented to the QAPI committee to identify any negative trends toward compliance. The QAPI committee will make further recommendations for improvement, if needed.	Completion Date: **02/25/2025** Status: **APPROVED** Date: **01/21/2025**

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F 0625 SS=D	Continued from page 12 Based on review of facility policy, clinical record review, and staff interviews, 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 two of three resident hospital transfers (Residents R39 and R52). Review of Resident R39's admission record indicated he was originally admitted 2/9/23, with diagnoses that included dementia(decline in mental abilities that affects thinking, memory, and reasoning), diabetes mellitus and hyperlipidemia Review of Resident R39's clinical record revealed that the resident was transferred to the hospital on 9/9/24, and returned to the facility on 9/11/24. Review of Resident R39'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 9/9/24.	F 0625		

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F 0625 SS=D	Continued from page 13 Review of Resident R52's admission record indicated she was originally admitted on 10/25/23, with diagnoses that included surgical aftercare, muscle weakness and venous insufficiency. Review of the clinical record indicated Resident R52 was transferred to hospital on 10/13/24, and did not return to the facility. Review of Resident R52'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 10/13/24. During an interview on 1/9/25, at 10:30 a.m. Director of Nursing (DON) confirmed that the facility failed to notify the resident or resident's representative of the facility bed-hold policy for two of three resident hospital transfers as required (Resident R39, R52). 28 Pa. Code 201.29 (a)(c)(2) Resident rights.	F 0625		

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F 0637 SS=D	483.20(b)(2)(ii) Comprehensive Assessment After Signifcant Chg §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by:	F 0637	The Director of Nursing/designee will complete an audit of any resident admitted to hospice since Jan 1, 2025 to ensure to ensure that their MDS significant change includes documentation of hospice services. There were no negative outcomes from resident R3 or R8 not having a significant Change MDS prior to being admitted to hospice. The Director of Nursing/designee will educate the appropriate nursing staff on the appropriate documentation needed before a resident admits to hospice services. The LNAC/designee will conduct weekly audits for four weeks after any significant change MDS is completed to ensure the required documentation is present. The audit results will be submitted to the QAPI committee for review for any trends that may require further improvement plans.	Completion Date: **02/25/2025** Status: **APPROVED** Date: **01/21/2025**

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: _____	01/09/2025

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F 0637 SS=D	Continued from page 15 Based on clinical record review and staff interview, it was determined that the facility failed to complete a significant change Minimum Data Set (MDS-assessments completed indicating a change in condition of a resident requiring change in care) assessment for two of three residents reviewed (Residents R3 and R8). Findings include: Review of the Resident Assessment Instrument 3.0 User's Manual (reference used to complete an MDS) effective October 2023, indicated that the facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. Review of the clinical record revealed that Resident R3 was admitted to the facility on 8/11/17. Review of Resident R3's MDS dated 11/7/24,	F 0637		

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F 0637 SS=D	Continued from page 16 indicated diagnoses of high blood pressure, depression, and dementia (a group of symptoms that affects memory, thinking and interferes with daily life). Section O-Special Treatments, Procedures, and Programs indicated hospice care while a resident. Review of physician order dated 11/11/24, indicated Resident R3 was admitted under hospice services. Review of Resident R3's MDS assessments revealed a MDS significant change was not completed to include hospice services. Review of the clinical record revealed that Resident R8 was admitted to the facility on 6/15/23. Review of Resident R8's MDS dated 12/18/24, indicated diagnoses of high blood pressure, dementia, and Parkinson's disease (neuromuscular disorder causing tremors and difficulty walking). Section O-Special Treatments, Procedures, and	F 0637		

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F 0637 SS=D	Continued from page 17 Programs indicated hospice care while a resident. Review of physician order dated 2/20/24, indicated Resident R8 was admitted to hospice on 2/20/24. Review of Resident R8's MDS assessments revealed a MDS significant change was not completed to include hospice services. During an interview on 1/8/25, at 3:07 p.m. Licensed Practical Nurse Assessment Coordinator Employee E5 confirmed that a significant change MDS was not completed for Resident R3 and R8. During an interview on 1/8/25, at approximately 3:10 p.m. the Director of Nursing confirmed the facility failed to complete a significant change MDS assessment for two of three residents reviewed (Residents R3 and R8). 28 Pa. Code: 211.5(f) Clinical records.	F 0637		

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F 0655 SS=D	483.21(a)(1)-(3) Baseline Care Plan §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions.	F 0655	The R156 care plan was updated to indicate that the resident has a Foley catheter. R156 was not affected by the deficient practice of failure to include a Foley catheter in the line care plan. The LNAC/ designee will educate team members on the need to include catheters in the baseline care plan. The LNAC/designee will conduct weekly audits for four weeks of baseline care plans for newly admitted residents to ensure necessary resident care information is present on the care plan. The audit results will be submitted to the QAPI committee for review for any trends and the need for any performance improvement plans.	Completion Date: **02/25/2025** Status: **APPROVED** Date: **01/21/2025**

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F 0655 SS=D	Continued from page 19 (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by:	F 0655		

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F 0655 SS=D	Continued from page 20 Based on a review of facility policy, clinical records, and staff interview, it was determined that the facility failed to develop a baseline care plan for one of three residents (Resident R156). Findings include: Review of facility policy "Baseline Care Plans" dated 11/5/24, indicated a baseline plan of care to meet the residents immediate needs and provide instruction needed to provide effective and person-centered care shall be developed for each resident within forty-eight hours of admission. Review of the clinical record revealed Resident R156 was admitted to the facility on 1/4/25, with diagnoses of dementia (loss of intellectual functioning), benign prostatic hyperplasia (BPH-enlargement of the prostate gland), and depression. During an observation on 1/8/25, at 10:31 a.m. Resident R156 was in his room sitting in his wheelchair, a foley catheter bag was noted attached	F 0655		

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F 0655 SS=D	Continued from page 21 to chair. Review of Resident R156's physician orders dated 1/4/25, indicated Resident R156 has a 16 french (size) 10cc bulb (holds catheter in place in the bladder). Review on 1/8/25, at 1:00 p.m. Resident 156's baseline care plan failed to include interventions for the care of the foley catheter. During an interview completed on 1/8/25, at 1:23 p.m. Licensed Practical Nurse (LPN) Employee E5 confirmed Resident R156's baseline care plan did not include interventions for the foley catheter, and that the facility failed to develop a baseline care plan for one of three residents (Resident R156). 28 Pa. Code: 211.11 (a)(c)(d) Resident care plan. 28 Pa. Code: 211.12(d)(1)(5) Nursing services.	F 0655		
F 0695 SS=D		F 0695		

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F 0695 SS=D	Continued from page 22 483.25(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	The director of nursing/designees completed an audit of Oxygen Tubing/ Bipap/ Nebulizers to review all respiratory equipment currently in use to ensure that each required item is properly dated and stored as per infection control guidelines. Any items undated or improperly stored were removed and replaced at the time of discovery. All residents with oxygen tubing or nebulizers had the potential to be affected by the alleged deficient practice. There were no known negative outcomes. The DON/Designee will provide training for nursing and respiratory therapy staff on the proper procedure for dating and storing respiratory equipment. This training will include the appropriate technique for labeling oxygen tubing. Nebulizer equipment and storing bipap masks with the correct date of use and the recommended duration for tubing replacement according to infection control policies. The DON/Designee will conduct	Completion Date: **02/25/2025** Status: **APPROVED** Date: **01/21/2025**

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F 0695 SS=D	Continued from page 23	F 0695	weekly audits of respiratory equipment to ensure proper labeling and storing is be completed for four weeks. Results of audits will be submitted to the QAPI committee to review and identify any trends that may require further follow up recommendations. _____ _____	

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F 0695 SS=D	Continued from page 24 Based on review of facility policy, observations, staff interviews, and clinical record review, it was determined that the facility failed to provide appropriate respiratory care for three of four residents (Residents R9, R20, and R205). Findings include: Review of facility policy "Oxygen Administration" dated 11/5/24, indicated oxygen is administered to residents who need it, consistent with professional standards of practice, the comprehensive person-centered care plans, and the residents ' goal and preferences. Change oxygen tubing and tubing weekly and as needed if it becomes soiled or contaminated. Change humidifier bottle when empty or weekly. Review of facility policy "Infection Prevention and Control Program" dated 11/5/24, indicated the facility has established and maintains an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment.	F 0695		

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F 0695 SS=D	Continued from page 25 Review of the clinical record indicated Resident R9 was admitted to the facility on 7/10/24. Review of Resident R9's Minimum Data Set (MDS - a periodic assessment of care needs) dated 10/23/24, indicated diagnoses of hypertension (high blood pressure), diabetes (a metabolic disorder in which the body has high sugar levels for prolonged periods of time), and sleep apnea (a sleeping disorder in which breathing repeatedly stops and starts). Section O0100, C1 Oxygen therapy was marked and section G1 was checked indicating use of Continuous Positive Airway Pressure (CPAP - a treatment that uses a machine to deliver air pressure to help a person breathe while sleeping). Review of a physician's active orders dated 1/3/25, indicated to administer oxygen via nasal cannula (a medical device that provides supplemental oxygen to patients through two prongs inserted into the nostrils) continuously at 4 liters per minute. Change oxygen tubing and humidifier every week.	F 0695		

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F 0695 SS=D	Continued from page 26 Review of physician's active orders dated 1/4/25, indicated CPAP at bedtime, pressure 12. Apply at bedtime and remove in the morning. During an observation on 1/7/25, at 12:20 p.m. Resident R9 was sitting in her wheelchair receiving 4 liters per minute of oxygen via nasal cannula. No date was present on the oxygen nasal cannula and humidification bottle. CPAP mask was laying on a chair bedside the nightstand and failed to be stored in a bag, when not in use. During an interview on 1/7/25, at 12:35 p.m. Licensed Practical Nurse (LPN) Employee E8 confirmed that no date was present on Resident R9's nasal cannula tubing and humidification bottle, and her CPAP mask was not properly stored in a bag, when not in use. Review of Resident R20's clinical record indicated an admission date of 4/23/24.	F 0695		

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F 0695 SS=D	Continued from page 27 Review of Resident R20's MDS dated 11/25/24, indicated the diagnosis of respiratory failure (not enough oxygen in the body), hypertension (high blood pressure), and diabetes (high sugar in the blood). Review of Resident R20's physician order dated 12/13/24, indicated to wear CPAP through nighttime. Review of Resident R20's care plan dated 3/5/24, with revision on 11/29/24, indicated Resident R20 has CPAP machine to wear at night. During an observation on 1/7/25, at 10:18 a.m. Resident R20's CPAP mask was sitting on dresser not properly stored in a bag. During an interview completed on 1/7/25 at 10:23 a.m. LPN Employee E1 confirmed the CPAP mask was not properly stored in a bag. Review of the clinical record indicated Resident	F 0695		

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F 0695 SS=D	Continued from page 28 R205 was admitted to the facility on 1/2/25. Review of Resident R205's MDS dated 1/8/25, indicated diagnoses of pneumonia (infection that inflames air sacs in one or both lungs, which may fill with fluid), anemia (a condition in which the blood doesn't have enough red blood cells to carry oxygen all through the body), and asthma (airway becomes inflamed, narrow, and swell and makes breathing difficult). Review of a physician's active orders dated 1/3/25, indicated to administer Ipratropium-Albuterol (medication causing your airway to relax and make breathing easier) every two hours as needed for shortness of breath. During an observation on 1/7/25, at 1:02 p.m. Resident R205 was sitting in his chair with nebulizer (a machine used to administer medication) on his nightstand. Nebulizer tubing was not dated and was not stored in a bag, when not in use.	F 0695		

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F 0695 SS=D	Continued from page 29 During an interview on 1/7/25, at 1:14 p.m. Registered Nurse (RN) Employee E2 confirmed that no date was present on R205's nebulizer tubing, and his mask was not properly stored in a bag, when not in use. During an interview on 1/7/25, at 2:45 p.m. the Director of Nursing confirmed that the facility failed to provide appropriate respiratory care for three of four residents (Residents R9, R20, and R205). 28 Pa. Code: 201.14(a) Responsibility of licensee. 28 Pa. Code 211.12(d)(1)(2)(3)(5) Nursing services.	F 0695		
F 0755 SS=D		F 0755		

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F 0755 SS=D	Continued from page 30 483.45(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	The Director of Nursing/designees conducted an audit on the date of discovery of all medications left behind after resident discharge/death. The medications were immediately discarded according to policy. Any medications that have not been properly destroyed have been securely stored pending destruction NS medication disposition will be completed. DON/designee will audit residents that have been discharged since January 20, 2025 weekly for 4 weeks to ensure medication disposition forms have been completed and medication has been destroyed. DON/ Designee will train nursing and pharmacy team members on the proper procedures for medication destruction following a resident's death or discharge. The training will include:  The importance of timely medication destruction.	Completion Date: **02/25/2025** Status: **APPROVED** Date: **01/21/2025**

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: _____	01/09/2025

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LONGWOOD AT OAKMONT STATE LICENSE NUMBER: **017202**	**500 ROUTE 909** **VERONA, PA 15147**

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F 0755 SS=D	Continued from page 31 This REQUIREMENT is not met as evidenced by:	F 0755	 Procedures for identifying medications that need to be destroyed.  Documentation and verification requirements for destruction.  Compliance with state and federal regulations regarding the disposal of medications. Results of audits will be submitted to the QAPI committee for review of any trends and further recommendations.	

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F 0755 SS=D	Continued from page 32 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 (Countryside Medication room). Findings: Review of facility "Storage of Medications" policy dated 11/5/24, indicated that medications and biologicals are stored safely, securely, and properly, following manufacturer ' s recommendations or those of the supplier. The medication supply is accessible only to licensed nursing personnel, pharmacy personnel or staff members lawfully authorized to administer medications. Review of facility "Disposal of Medications-Discontinued Medications" policy dated 11/524, indicated medications not returned to the pharmacy are destroyed in accordance with the Medication Destruction policy.	F 0755		

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F 0755 SS=D	Continued from page 33 During a medication room review on 1/8/25, at 1:30 p.m. two plastic basins with medications was observed sitting on the counter, unsecured. Medications were dated November 2024 from the pharmacy. The medications observed were: - Atropine (used to decrease saliva) - 1 bottle. - Pantoprazole (used to treat acid reflex) - 40 mg 3 pills. - Pantoprazole - 20 mg 2 pills. - Calcium 600/800 mg 4 pills. - Eliquis (used to prevent or treat blood clots- 5 mg 7 pills - Tums- 1 bottle. - Centrum (a vitamin) - 1 bottle. - Scopolamine patch (used to decrease saliva)- 8 patches. - Nitroglycerin (used to treat chest pain) -1 bottle. - Simethicone (used to treat upset stomach) - 1 bottle. - Albuterol (used to breathing problems)- 12 vials. - Tylenol - 650 mg 27 pills. - Aspirin (a blood thinner) - 81 mg 2 pills.	F 0755		

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F 0755 SS=D	Continued from page 34 - Lisinopril (used for high blood pressure) -5 mg 2 pills. - Lisinopril- 40 mg 1 pill. - Metoprolol (used for high blood pressure) -25 mg 2 pills. - Zoloft (used for depression) -100 mg 2 pills. - Tylenol Cold and Flu -5 capsules. - Vitamin D -1000 units 2 pills. - Atorvastatin (used for high cholesterol) 40 mg 3 pills. - Montelukast (used to treat allergies) -10 mg 3 pills. - Senna (used for constipation)- 8.6 mg 3 pills. - Melatonin (used to help sleep) -3 mg 1 pill. - Seroquel (used for mental health conditions)- 25 mg 1 pill. - Carvedilol (used for high blood pressure) - 6.25 mg 2 pills. - Depakote (used for seizures) - 125 mg 2 pills. - Fluoxetine (used to treat depression) - 20 mg 1 pill. - Remeron (used to treat depression) - 15 mg 1 pill. - Simvastatin (used to treat high cholesterol) - 20	F 0755		

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F 0755 SS=D	Continued from page 35 mg 1 pill. - Ferrous Sulfate (an iron supplement) - 325 mg 1 pill. - Multivitamin -1 pill. During an interview on 1/8/25, at 1:05 p.m. Licensed Practical Nurse (LPN) Employee E8 stated, "These are old medications. We don't have any paperwork to complete prior to destroying the medications. They tell us to destroy the medications when we have time using the med buster (a solution that dissolves medication). There is no accountability paperwork that goes in residents medical record that I know of." During an interview on 1/8/25, at 1:30 p.m. the Director of Nursing confirmed that the facility failed to dispose or reconcile discontinued medication in a timely manner for one of two medication rooms reviewed (Countryside Medication room). 28 Pa. Code: 211.12(d)(1)(3)(5) Nursing services.	F 0755		

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F 0761 SS=D	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	The Director of Nursing and designees organized the medication carts in all neighborhoods on the date of discovery to include a labeled drawer designated for topical medications. There were no known negative outcomes from the deficient practice of not properly storing biological medications separately from other medications. The Director of Nursing/ Designee will educate nursing staff on the proper storage of biological medications on medication carts /treatment carts by the compliance date. The Director of Nursing /Designee will conduct weekly audits for 4 weeks of medication carts/ treatment carts to ensure biological items are stored properly in designated drawers. The results of audits will be submitted to the QAPI committee to determine if any negative trends exist that may require further intervention for improvement.	Completion Date: **02/25/2025** Status: **APPROVED** Date: **01/21/2025**

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F 0761 SS=D	Continued from page 37 Based on review of facility policies, observations, and staff interviews, it was determined that the facility failed to store medications and biologicals properly and securely in one of three medications carts (Riverside medication cart). Findings include: Review of the facility policy "Storage of Medications" dated 11/5/24, indicates medications and biologicals are stored safely, securely, and properly. Orally administered medications are kept separate from externally used medications and treatments such as including but not inclusive to ointments, creams, and vaginal products. During an interview and observation on 1/7/25, at 10:26 a.m. it was revealed that the Riverside medication carts fourth drawer contained dividers that were labeled with room numbers and contained various creams, ointments, and gels. Licensed Practical Nurse (LPN) Employee E1 stated "we don't have a separate treatment cart; all the	F 0761		

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F 0761 SS=D	Continued from page 38 treatments are kept in the medication cart". LPN Employee E1 referred to this drawer as the "treatment drawer". The fifth drawer contained: . An open box of paper tape. . A container of antifungal powder. . A box of vaginal cream commingling with seven oral Tussin liquid medication bottles. . One Ventolin inhaler and three Nasal sprays commingling with dry dressing supplies that included but not inclusive to abdominal pads, 4x4 gauze sponges, and multiple different cover dressings. The bottom drawer contained the following items commingling with respiratory treatment agents: . A tube of antifungal cream. . A tube of Voltaren gel. . A tube of hydrocortisone cream. . Two containers of Silvadene ointment. During an interview completed on 1/7/25, at 10:38	F 0761		

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F 0761 SS=D	Continued from page 39 a.m. LPN Employee E1 confirmed the above observations and confirmed that the facility failed to store medications and biologicals properly and securely in one of three medications carts (Riverside medication cart). 28 Pa. Code: 211.9(a)(1)(h)(k)(l)(1) Pharmacy services. 28 Pa. Code:211.12(d)(1)(2)(3)(5) Nursing services.	F 0761		
F 0808 SS=D		F 0808		

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F 0808 SS=D	Continued from page 40 483.60(e)(1)(2) Therapeutic Diet Prescribed by Physician §483.60(e) Therapeutic Diets §483.60(e)(1) Therapeutic diets must be prescribed by the attending physician. §483.60(e)(2) The attending physician may delegate to a registered or licensed dietitian the task of prescribing a resident's diet, including a therapeutic diet, to the extent allowed by State law. This REQUIREMENT is not met as evidenced by:	F 0808	Resident R4 was not affected by the deficient practice of not providing items consistent with their prescribed diet as the issue was discovered and addressed before the soup was served. There was also no negative affect for resident R4 who did not have orders for the two handle cup adaptive equipment. The Dietician/designee or the Director of Nursing/designee will audit orders for residents with specialty diets and/or adaptive dining equipment to ensure the appropriate orders are in place. The Dining Services Director/designee will educate team members on ensuring residents receive food/diet items as prescribed by physician. orders by DON/designee. The Director of Nursing, Dining Services manager, dietician or designee will conduct observation audits at least five times weekly for 4 weeks on	Completion Date: **02/25/2025** Status: **APPROVED** Date: **01/21/2025**

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F 0808 SS=D	Continued from page 41	F 0808	residents who are on modified diets to ensure team members are following the MD order. The audits will be completed and present to the QAPI committee for further review and follow up if there are any negative trends identified.	

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F 0808 SS=D	Continued from page 42 Based on review of facility policy, clinical record, observations and staff and resident interviews, it was determined that the facility failed provide food items consistent with the prescribed diet order for one of four residents observed during dining (Resident R4). Findings include: Review of physician orders for Resident R4 confirmed a diet order dated 11/18/24, for "Low Lactose diet, Mechanical Soft Ground Meat texture, Nectar/Mildly Thick liquids." During observations during dining, on 1/7/24, at 12:15 p.m. revealed Resident R4 was served turkey vegetable soup and had her liquids in a sippy cup. Resident R4 revealed no orders for adaptive equipment. Interview with Dietary Director Employee E9 confirmed the above-mentioned findings. Interview with Director of Nursing (DON) on	F 0808		

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F 0808 SS=D	Continued from page 43 11/8/24, at 2:00 p.m. confirmed Resident R4 should have not been served the soup or the sippy cup. 28 Pa. Code 211.6(a) Dietary Services.	F 0808		
F 0849 SS=D		F 0849		

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F 0849 SS=D	Continued from page 44 483.70(n)(1)-(4) Hospice Services §483.70(n) Hospice services. §483.70(n)(1) A long-term care (LTC) facility may do either of the following: (i) Arrange for the provision of hospice services through an agreement with one or more Medicare-certified hospices. (ii) Not arrange for the provision of hospice services at the facility through an agreement with a Medicare-certified hospice and assist the resident in transferring to a facility that will arrange for the provision of hospice services when a resident requests a transfer. §483.70(n)(2) If hospice care is furnished in an LTC facility through an agreement as specified in paragraph (o)(1)(i) of this section with a hospice, the LTC facility must meet the following requirements: (i) Ensure that the hospice services meet professional standards and principles that apply to individuals providing services in the facility, and to the timeliness of the services. (ii) Have a written agreement with the hospice that is signed by an authorized representative of the hospice and an authorized representative of the LTC facility before hospice care is furnished to any resident. The written agreement must set out at least the following: (A) The services the hospice will provide. (B) The hospice's responsibilities for determining the appropriate hospice plan of care as specified in §418.112 (d) of this chapter.	F 0849	The Director of Nursing/designee completed a whole house audit on 1/1/25 of active hospice residents to ensure MD orders were updated and plans include resident diagnoses for hospice and hospice contact information. Each resident has a form of internal communication from the assigned hospice. R3, R8, and R39 were not affected by the deficient practice of not having all the required documentation of hospice services on resident charts. The Director of Nursing/Designee will educate team members on the required documentation for the clinical record for resident hospice services admission. Each hospice resident has an internal communication process from the assigned hospice. The DON/designee will conduct weekly audits for 4 weeks of hospice residents to ensure they have a hospice order, diagnosis for hospice, and contact information for the resident's selected hospice service.	Completion Date: **02/25/2025** Status: **APPROVED** Date: **01/21/2025**

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F 0849 SS=D	Continued from page 45 (C) The services the LTC facility will continue to provide based on each resident's plan of care. (D) A communication process, including how the communication will be documented between the LTC facility and the hospice provider, to ensure that the needs of the resident are addressed and met 24 hours per day. (E) A provision that the LTC facility immediately notifies the hospice about the following: (1) A significant change in the resident's physical, mental, social, or emotional status. (2) Clinical complications that suggest a need to alter the plan of care. (3) A need to transfer the resident from the facility for any condition. (4) The resident's death. (F) A provision stating that the hospice assumes responsibility for determining the appropriate course of hospice care, including the determination to change the level of services provided. (G) An agreement that it is the LTC facility's responsibility to furnish 24-hour room and board care, meet the resident's personal care and nursing needs in coordination with the hospice representative, and ensure that the level of care provided is appropriately based on the individual resident's needs. (H) A delineation of the hospice's responsibilities, including but not limited to, providing medical direction and management of the patient; nursing; counseling (including spiritual, dietary, and bereavement); social work; providing medical supplies, durable medical equipment, and	F 0849	The Director of Nursing/designee(s) will audit for four weeks the communication books for each hospice resident to ensure the internal communication process is in place for resident served by the identified hospice. The results of audits will be submitted to the QAPI committee to review for any trends for which further improvement plans may need to be considered.	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0849 SS=D	Continued from page 46 drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related conditions; and all other hospice services that are necessary for the care of the resident's terminal illness and related conditions. (I) A provision that when the LTC facility personnel are responsible for the administration of prescribed therapies, including those therapies determined appropriate by the hospice and delineated in the hospice plan of care, the LTC facility personnel may administer the therapies where permitted by State law and as specified by the LTC facility. (J) A provision stating that the LTC facility must report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by hospice personnel, to the hospice administrator immediately when the LTC facility becomes aware of the alleged violation. (K) A delineation of the responsibilities of the hospice and the LTC facility to provide bereavement services to LTC facility staff. §483.70(n)(3) Each LTC facility arranging for the provision of hospice care under a written agreement must designate a member of the facility's interdisciplinary team who is responsible for working with hospice representatives to coordinate care to the resident provided by the LTC facility staff and hospice staff. The interdisciplinary team member must have a clinical background, function within their State scope of practice act, and have the ability to assess the resident or have access to someone that has the skills and	F 0849		

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: _____	01/09/2025

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F 0849 SS=D	Continued from page 47 capabilities to assess the resident. The designated interdisciplinary team member is responsible for the following: (i) Collaborating with hospice representatives and coordinating LTC facility staff participation in the hospice care planning process for those residents receiving these services. (ii) Communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the patient and family. (iii) Ensuring that the LTC facility communicates with the hospice medical director, the patient's attending physician, and other practitioners participating in the provision of care to the patient as needed to coordinate the hospice care with the medical care provided by other physicians. (iv) Obtaining the following information from the hospice: (A) The most recent hospice plan of care specific to each patient. (B) Hospice election form. (C) Physician certification and recertification of the terminal illness specific to each patient. (D) Names and contact information for hospice personnel involved in hospice care of each patient. (E) Instructions on how to access the hospice's 24-hour on-call system. (F) Hospice medication information specific to each patient. (G) Hospice physician and attending physician (if any)	F 0849		

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F 0849 SS=D	Continued from page 48 orders specific to each patient. (v) Ensuring that the LTC facility staff provides orientation in the policies and procedures of the facility, including patient rights, appropriate forms, and record keeping requirements, to hospice staff furnishing care to LTC residents. §483.70(n)(4) Each LTC facility providing hospice care under a written agreement must ensure that each resident's written plan of care includes both the most recent hospice plan of care and a description of the services furnished by the LTC facility to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, as required at §483.24. This REQUIREMENT is not met as evidenced by:	F 0849		

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F 0849 SS=D	Continued from page 49 Based on review of resident clinical records and staff interviews, it was determined the facility failed to obtain a physican order for hospice services and to ensure the coordination of hospice services (supportive services for end stage terminal illness) with facility services to meet the needs of each resident for end-of-life care for three of four residents (Resident R3, R8, and R39). Findings include: Review of the facility policy "Hospice Program" dated 11/5/24, indicated that when a resident has been diagnosed as terminally ill, the facility will contact hospice agency. When a resident participates in a hospice program, a coordinated plan of care between the facility, hospice agency and resident or family will be developed and shall include directives for managing pain and other uncomfortable symptoms. The care plan shall be revised and updated as necessary to reflect the resident's status.	F 0849		

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F 0849 SS=D	Continued from page 50 Review of the clinical record revealed that Resident R3 was admitted to the facility on 8/11/17. Review of Resident R3's MDS (Minimum Data Set-periodic assessment of resident care needs) dated 11/7/24, indicated diagnoses of high blood pressure, depression, and dementia (a group of symptoms that affects memory, thinking and interferes with daily life). Section O-Special Treatments, Procedures, and Programs indicated hospice care while a resident. Review of Resident R3's clinical record revealed a physician order dated 11/11/24, that resident is under hospice services, but did not include a diagnosis related to the need of hospice services. The facility failed to provide documentation completed by the hospice service, including admission into hospice, plan of care, communication between hospice service and facility, and contact information. Review of Resident R3's current comprehensive	F 0849		

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F 0849 SS=D	Continued from page 51 care plan failed to indicate a plan of care by the facility that displayed the coordination of hospice services by failing to include contact information for the hospice agency and how to access the hospice's 24 hour on-call system. Review of the clinical record revealed that Resident R8 was admitted to the facility on 6/15/23. Review of Resident R8's MDS dated 12/18/24, indicated diagnoses of high blood pressure, dementia, and Parkinson's disease (neuromuscular disorder causing tremors and difficulty walking). Section O-Special Treatments, Procedures, and Programs indicated hospice care while a resident. Review of Resident R8's clinical record revealed a physician order dated 2/20/24, that resident admitted to hospice services, but did not include a diagnosis related to the need of hospice services. Review of Resident R8's current comprehensive care plan failed to indicate a plan of care by the	F 0849		

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F 0849 SS=D	Continued from page 52 facility that displayed the coordination of hospice services by failing to include contact information for the hospice agency and how to access the hospice's 24 hour on-call system. Review of the admission record indicated Resident R39 was admitted to the facility on 2/9/23. Review of Resident R39's MDS, dated 12/18/24, indicated the diagnosis of dementia (decline in mental abilities that affects thinking, memory, and reasoning), diabetes mellitus and hyperlipidemia. Review of Resident R39's current physician orders indicated consult hospice care for evaluation and admit if appropriate on 12/13/2024. The order failed to include what vendor, and the diagnosis qualifying the resident for Hospice Services. Review of Resident R39's progress notes indicated resident's wife would like Bridges Hospice as the vendor.	F 0849		

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F 0849 SS=D	Continued from page 53 During an interview on 1/9/25, at 10:30 a.m. the Director of Nursing (DON) confirmed the facility failed to obtain a physican order for hospice services and to ensure the coordination of hospice services with facility services to meet the needs of each resident for end-of-life care for three of four residents (Resident R3, R8, and R39). 28 Pa. Code: 201.14(a) Responsibilities of licensee 28 Pa. Code: 201.18(a)(b)(1)(3) Management 28 Pa. Code: 201.20(a)(b)(c)(d) Staff development 28 Pa. Code: 211.10(c)(d) Resident care policies	F 0849		

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P 1020	Responsibility of licensee. (a) The licensee is responsible for meeting the minimum standards for the operation of a facility as set forth by the Department and by other Federal, State and local agencies responsible for the health and welfare of residents. This includes complying with all applicable Federal and State laws, and rules, regulations and orders issued by the Department and other Federal, State or local agencies. This REGULATION is not met as evidenced by:	P 1020	The 2025 infection control meetings have been established. Communication about scheduled infection control meetings will be sent to all committee members by the prior to each meeting. Committee members who do not RSVP or participate in the scheduled meeting will be asked to connect with the infection preventionist to review the summary of the meeting or the missing committee member may also view a securely recorded version of the meeting to share their feedback. he infection preventionist will ensure that attendance is documented for all meetings and whether the committee member participated in person, via zoom, or via recording. The sign in sheets will be shared with the QAPI committee to verify infection control committee required participation at least quarterly in 2025. Any identified trends by the QAPI or infection control committee will be addressed for performance improvement.	Completion Date: **02/25/2025** Status: **APPROVED** Date: **01/21/2025**

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

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P 1020	Continued from page 1 Based on staff interview and review of the facility's Infection Control Meeting attendance records, it was determined that the facility failed to ensure that all of the required nine multidisciplinary members were present at the Infection Control Meetings (a member from the community) for four of four quarters (Quarter 1, Quarter 2, Quarter 3, and Quarter 4) and laboratory personnel for one of four quarters (Quarter 3). Findings include: Review of Act 52 (The Act of March 20, 2002, P.L. 154, No. 13), known as the Medical Care Availability and Reduction of Error (MCARE) Act, Chapter 4, Section 403(1) Infection Control plan states, "A health care facility... shall develop and implement an internal infection control plan that shall include... a multidisciplinary committee including representatives from each of the following if applicable to that specific health care facility." A review of the applicable members at infection control meetings includes medical staff,	P 1020		

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P 1020	Continued from page 2 administration, laboratory personnel, nursing staff, pharmacy staff, physical plan personnel, patient safety officer, a community member, and a member of the infection control team. Review of the facility's Infection Control Meeting attendance records for Quarter 1 (January 2024, February 2024, March 2024), Quarter 2 (April 2024, May 2024, June 2024), Quarter 3 (July 2024, August 2024, September 2024), and Quarter 4 (October 2024, November 2024, and December 2024), failed to reveal that a member from the community was in attendance. Review of the facility's Infection Control Meeting attendance records for Quarter 3 (July 2024, August 2024, September 2024) failed to reveal that laboratory personnel were in attendance. During an interview completed on 1/9/25, at 11:53 a.m. the Nursing Home Administrator confirmed that the facility failed to ensure that all of the required nine multidisciplinary members were	P 1020		

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P 1020	Continued from page 3 present at the Infection Control Meetings (a member from the community) for four of four quarters (Quarter 1, Quarter 2, Quarter 3, and Quarter 4) and laboratory personnel for one of four quarters (Quarter 3).	P 1020		

Certified End Page

LONGWOOD AT OAKMONT

STATE LICENSE NUMBER: 017202

SURVEY EXIT DATE: 01/09/2025

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

Jeanne Parisi
Deputy Secretary for Quality Assurance

Debra L. Bogen, MD, FAAP
Secretary of Health

Pennsylvania
Department of Health

THIS IS A CERTIFICATION PAGE

PLEASE DO NOT DETACH

THIS PAGE IS NOW PART OF THIS SURVEY