STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395986	A. BLDG: 00 B. WING:	01/16/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
KITTANNING HEALTH & REHAB CENTER STATE LICENSE NUMBER: **234802**	**120 KITTANNING CARE DRIVE** **KITTANNING, PA 16201**

(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 two complaints and two events completed on January 16, 2025, it was determined that Kittanning Health & Rehab Center 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 0558 SS=D		F 0558		

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 0558 SS=D	Continued from page 1 483.10(e)(3) Reasonable Accommodations Needs/Preferences §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by:	F 0558	Resident #4 was immediately provided call bell. To identify other residents that have the potential to be affected, the Director of Nursing (DON)/designee completed a whole house sweep to ensure residents call bells were within reach. There were no negative findings. To prevent this from recurring, the Regional Director of Clinical Services (RDCS)/designee educated staff on ensuring that a resident's call bell is within reach. To monitor and maintain ongoing compliance the DON/designee will audit 3 residents weekly x4 then monthly x 2 to ensure that call bell is within reach. Negative findings will be addressed. Ad Hoc education will be provided as needed. The results of the audits will be forwarded to the facility Quality Assurance Performance Improvement (QAPI) committee for	Completion Date: **02/11/2025** Status: **APPROVED** Date: **02/07/2025**

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 0558 SS=D	Continued from page 2	F 0558	further review and recommendations.	

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 0558 SS=D	Continued from page 3 Based on review of facility policy, clinical records, and staff interviews, it was determined that the facility failed to make certain call bells were in reach for one of six residents as required (Resident R4). Findings include: The facility policy "Call Lights" dated 2/24/23, last reviewed 1/2/24, indicated it is the policy of the facility to provide residents with a means of communicating with staff. A call system is installed in each resident room. The facility responds to residents needs and requests. Review of Resident R4's clinical record indicated admission to the facility on 12/15/23. Review of Resident R4's Minimum Data Set (MDS - a periodic assessment of care needs) dated 12/28/24, indicated diagnoses of hypertension (high blood pressure) polyneuropathy (disease that affects many nerves in the body) and depression.	F 0558		

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F 0558 SS=D	Continued from page 4 Review of Resident R4's care plan dated 1/17/24, indicated the resident was at risk for falling due to poor safety awareness. It was indicated to keep the call light in reach at all times. During an interview and observation on 1/12/25, at 9:40 a.m. Resident R4 was sitting in her wheelchair in her room. The resident was observed slouched down in her wheelchair, yelling "My back". Resident was in obvious distress, crying out. Interview on 1/12/25 at 9:47 a.m. Nurse Aide, Employee E11 confirmed the call bell was not in reach of Resident R4. Interview on 1/12/25, at 1:50 p.m. the Nursing Home Administrator confirmed facility failed to make certain call bells were in reach for one of six residents as required. (Resident R4). 28 Pa. Code: 211.10(c)(d) Resident care policies. 28 Pa. Code: 211.12(d)(1)(2)(3)(5) Nursing services.	F 0558		

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F 0558 SS=D	Continued from page 5 28 Pa Code: 201.29 (I)(o) Resident rights.	F 0558		
F 0578 SS=D		F 0578		

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F 0578 SS=D	Continued from page 6 483.10(c)(6)(8)(g)(12)(i)-(v) Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance	F 0578	The resident and/or resident representative for Resident # 87 were immediately provided an opportunity to develop an advance directive. To identify other residents that have the potential to be affected, the DON/designee completed a house audit to ensure residents and/or resident representatives have been provided an opportunity to develop an advance directive. Corrections will be made as needed. To prevent this from recurring, the RDCS/designee educated licensed nursing and Social Services on the regulatory requirements of F578 regarding ensuring residents and/or resident representatives are provided an opportunity to develop an advance directive. To monitor and maintain ongoing compliance the DON/designee will audit 3 residents weekly x4 then monthly x 2 to ensure residents and /or families are provided an opportunity to develop an advance	Completion Date: **02/11/2025** Status: **APPROVED** Date: **02/07/2025**

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F 0578 SS=D	Continued from page 7 directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by:	F 0578	directives. Negative findings will be addressed. Ad Hoc education will be provided as needed. The results of the audits will be forwarded to the facility Quality Assurance Performance Improvement (QAPI) committee for further review and recommendations.	

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F 0578 SS=D	Continued from page 8 Based on review of facility policy, clinical records, and staff interview, it was determined that the facility failed to provide the opportunity to formulate an advance directive (a written instruction such as a living will or durable power of attorney for health care for when the individual is incapacitated) for one of two residents (Resident R87). Findings include: A review of the facility "Resident Rights Regarding Treatment and Advance Directives" dated 1/12/25, and previously dated 1/2/24, indicated that Advance Directives will be discussed with resident or their representative to determine if any Advance Directives have been chosen or of the resident has any questions. Review of Resident R87's admission record indicated the resident was admitted to the facility 11/15/24. A review of Resident R87's Minimum Data Set	F 0578		

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F 0578 SS=D	Continued from page 9 (MDS - periodic assessment of care needs) dated 11/21/24, included diagnoses of high blood pressure, diabetes (a metabolic disorder in which the body has high sugar levels for prolonged periods of time), and morbid obesity due to excess calories. A review of the clinical record failed to reveal an Advanced Directive or documentation that Resident R87 was given the opportunity to formulate an Advanced Directive. During an interview on 1/15/25, at 12:23 p.m. Social Services Director Employee E6 confirmed that the clinical record did not include documentation that Resident R87 was afforded the opportunity to formulate Advanced Directives. 28 Pa. Code: 201.29(b)(d)(j) Resident rights.	F 0578		
F 0584 SS=D		F 0584		

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 0584 SS=D	Continued from page 10 483.10(i)(1)-(7) Safe/Clean/Comfortable/Homelike Environment §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all	F 0584	During the survey, the sheets were changed for Resident #47 and housekeeping cleaned the floor. To identify other areas of concern, the housekeeping director/ designee completed environmental rounds, cleaned debris, mopped/swept floors as needed, and ensured bed sheets were clean. To prevent this from recurring, The Nursing Home Administrator (NHA)/ designee educated facility staff on the regulatory requirements of F584 and ensuring a safe, clean and home-like environment. To monitor and maintain ongoing compliance, the NHA/designee will audit 10 resident rooms weekly x4 then monthly x 2 to ensure residents have a safe, clean and home-like environment (sheets and floor do not have any substance on them). Negative findings will be placed on a concern form and addressed. Ad hoc education will be provided as needed.	Completion Date: **02/11/2025** Status: **APPROVED** Date: **02/07/2025**

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F 0584 SS=D	Continued from page 11 areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by:	F 0584	The results of the audits will be forwarded to the facility Quality Assurance Performance Improvement (QAPI) committee for further review and recommendations.	

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F 0584 SS=D	Continued from page 12 Based on facility policy review, observations, and resident and staff interviews, it was determined that the facility failed to maintain a safe, clean, and home-like environment for one of three sampled residents (Resident R47). Findings include: During observations on 1/14/25, at 9:54 a.m. Resident R47's bed was found with red substance on his sheets and red substance on the floor next to his bed. During an interview on 1/14/25, at 9:55 a.m. Licensed Practical Nurse (LPN) Employee E4 confirmed that the facility failed to maintain a safe, clean, and home-like environment for Resident R47 as required. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18(b)(1)(3) Management	F 0584		

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F 0584 SS=D	Continued from page 13	F 0584		
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 facility cannot retroactively go back and make corrections. Moving forward, the facility will report allegations of resident to resident abuse in the required timeframe. To identify other residents that have the potential to be affected, the DON/designee completed an audit of current resident events from date of exit (1/16/2025 to current) to ensure timely reporting if needed. Corrections will be made as needed. To prevent this from recurring, the RDCS provided education to the NHA and DON on the regulatory requirements of F609 and timely reporting of resident to resident abuse. To monitor and maintain ongoing compliance the NHA/designee will audit resident events weekly x4 then monthly x 2 to ensure those occurrences that meet the requirement are reported timely. Negative findings will be addressed. Ad Hoc education will be provided	Completion Date: **02/11/2025** Status: **APPROVED** Date: **02/10/2025**

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F 0609 SS=D	Continued from page 15	F 0609	as needed. Facility submitted event to ERS-event #1070939.	

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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 abuse in the required timeframe one of four residents (Resident R80). Findings include: Review of facility policy Review of facility policy "Abuse, Neglect, and Exploitation" dated 1/2/24, last reviewed 1/12/25, indicated all allegations of abuse, neglect, involuntary seclusion, injuries of unknown source, and misappropriation of resident property must be reported immediately to the Administrator, Director of Nursing, and to the applicable State Agency. All serious incidents involving a resident will be reported to the Department of Health (State Agency) field office within 24 hours. Review of the clinical record indicated Resident R80 was admitted to the facility on 8/8/23.	F 0609		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395986	A. BLDG: __00_____ B. WING: _____	01/16/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
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F 0609 SS=D	Continued from page 17 Review of Resident R80's Minimum Data Set (MDS - a periodic assessment of care needs) dated 10/22/24, indicated diagnoses of anemia (too little iron in the blood), dementia (a group of symptoms that affects memory, thinking and interferes with daily life), and depression (a constant feeling of sadness and loss of interest). Review of a progress note dated 12/31/24, at 3:46 a.m. stated, "According to Nurse Aide on unit, Resident R80 was walking in the hallway with Resident R66 when Resident R66 hit Resident R80's face with her hand and her left side with a cane. Staff separated the two and Resident R80 didn't say what precipitated the violence but expressed fear of it happening again. No obvious signs of trauma on Resident R80. MD (physician) and Social Services notified and family to be notified on 7 a.m. - 3 p.m. shift." Review of incidents submitted to the State Agency on 1/16/25, at 8:50 a.m. did not include the resident-to-resident abuse allegation on 12/31/24.	F 0609		

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F 0609 SS=D	Continued from page 18 During an interview on 1/16/25, at 5:46 p.m. the Nursing Home Administrator (NHA) stated that the Director of Nursing confirmed that he did not report the resident-to-resident abuse allegation that occurred on 12/31/24. During an interview on 1/16/25, at 5:46 p.m. the NHA confirmed that the facility failed to report an allegation of abuse in the required timeframe one of four residents (Resident R80). 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		
F 0622 SS=E		F 0622		

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 0622 SS=E	Continued from page 19 483.15(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	Facility is unable to retroactively make corrections for Residents #21, #30 and #78. Moving forward the facility will make certain the necessary resident information is communicated to the receiving health care provider. To identify other residents, the DON/designee performed house audit on transfer and discharge from 1/16/2025 to present to ensure the necessary resident information is communicated to the receiving health care provider. There were no negative findings. To prevent this from recurring, the RDCS provided education to the nursing staff on the regulatory requirements of F0622, for transfer and discharge documentation ensuring necessary resident information is communicated to the receiving health care provider, which includes resident care plan goals, advanced directive information, specific instructions for ongoing care, resident representative	Completion Date: **02/11/2025** Status: **APPROVED** Date: **02/07/2025**

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 0622 SS=E	Continued from page 20 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	information and resident specific needs To monitor and maintain ongoing compliance the DON/designee will audit resident transfers 5days weekly x4 weeks then monthly x2 to ensure necessary resident information is communicated to the receiving health care provide. Negative findings will be addressed. Ad Hoc education will be provided as needed. The results of the audits will be forwarded to the facility Quality Assurance Performance Improvement (QAPI) committee for further review and recommendations.	

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F 0622 SS=E	Continued from page 21 (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. This REQUIREMENT is not met as evidenced by:	F 0622		

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F 0622 SS=E	Continued from page 22 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 three of three residents with facility-initiated transfers (Resident R21, R30, and R78). The findings include: Review of the clinical record indicated Resident R21 was admitted to the facility on 9/14/22. Review of Resident R21's Minimum Data Set (MDS - a periodic assessment of care needs) dated 11/6/24, indicated diagnoses of high blood pressure, hip fracture, and malnutrition (lack of sufficient nutrients to the body). Review of Resident 21's clinical record revealed that the resident was transferred to the hospital on 10/19/24. Review of Resident R21's clinical record revealed	F 0622		

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F 0622 SS=E	Continued from page 23 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 care plan goals, advanced directive information, specific instructions for ongoing care, resident representative information, and all information necessary to meet the resident's specific needs at the receiving facility. Review of the clinical record indicated Resident R30 was admitted to the facility on 1/24/21. Review of Resident R30's MDS dated 12/10/24, indicated diagnoses of Alzheimer's Disease (a progressive disease that destroys memory and other important mental functions), dementia (a group of symptoms that affects memory, thinking and interferes with daily life), and senile degeneration of the brain. Review of Resident R30's clinical record revealed that the resident was transferred to the hospital on	F 0622		

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F 0622 SS=E	Continued from page 24 2/21/24. Review of Resident R30'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 care plan goals, advanced directive information, specific instructions for ongoing care, resident representative information, and all information necessary to meet the resident's specific needs at the receiving facility. Review of the clinical record indicated Resident R78 was admitted to the facility on 10/20/23. Review of Resident R78's MDS dated 12/11/24, indicated diagnoses of Alzheimer's Disease, dementia, and malnutrition. Review of Resident R78's clinical record revealed that the resident was transferred to the hospital on 12/1/24.	F 0622		

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F 0622 SS=E	Continued from page 25 Review of Resident R78'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 care plan goals, advanced directive information, specific instructions for ongoing care, resident representative information, and all information necessary to meet the resident's specific needs at the receiving facility. During an interview on 1/15/25, at 1:05 p.m. the Director of Nursing confirmed that there was no evidence that the necessary information was communicated to the receiving health care institution or provider upon transfer for three out of three residents sampled with facility-initiated transfers (Residents R21, R30, and R78). 28 Pa. Code 201.29 (a)(c.3)(2) Resident rights.	F 0622		

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F 0625 SS=E		F 0625		

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F 0625 SS=E	Continued from page 27 483.15(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	Facility is unable to retroactively send a bed hold policy to Residents #21, #30 and #78 or their RP. Moving forward the facility will make certain residents/responsible parties will be provided a bed hold policy when a resident is transferred to the hospital. To identify other residents, the DON/designee performed house audit of current residents in the hospital to ensure Resident / RP were provided a bed- hold policy. There were no negative findings. To prevent this from recurring, the NHA/designee will educate licensed nursing staff and SS on the regulatory requirements of F625 and facility bed- hold policy. To monitor and maintain ongoing compliance the DON/designee will audit resident transfers 5days weekly x4 weeks then monthly x2 to ensure resident or residents representative are notified of the facility bed-hold policy. Negative	Completion Date: **02/11/2025** Status: **APPROVED** Date: **02/07/2025**

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F 0625 SS=E	Continued from page 28	F 0625	findings will be addressed. Ad Hoc education will be provided as needed. The results of the audits will be forwarded to the facility Quality Assurance Performance Improvement (QAPI) committee for further review and recommendations.	

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F 0625 SS=E	Continued from page 29 Based on review of facility policy, clinical records, 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 three of three resident hospital transfers or therapeutic leave of absence (Resident R21, R30 and R78). Findings Include: Review of the facility policy "Bed Hold Notice" dated 1/12/25, and previously dated 1/2/24, indicated that the bed hold policy will be provided to residents at the time of transfer. In the case of an emergency, the paperwork should be provided within 24 hours. Review of the clinical record indicated Resident R21 was admitted to the facility on 9/14/22. Review of Resident R21's Minimum Data Set (MDS - a periodic assessment of care needs) dated	F 0625		

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F 0625 SS=E	Continued from page 30 11/6/24, indicated diagnoses of high blood pressure, hip fracture, and malnutrition (lack of sufficient nutrients to the body). Review of Resident 21's clinical record revealed that the resident was transferred to the hospital on 10/19/24, and returned to the facility on 10/31/24. Review of Resident R21'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 10/19/24. Review of the clinical record indicated Resident R30 was admitted to the facility on 1/24/21. Review of Resident R30's MDS dated 12/10/24, indicated diagnoses of Alzheimer's Disease (a progressive disease that destroys memory and other important mental functions), dementia (a group of symptoms that affects memory, thinking and interferes with daily life), and senile degeneration of	F 0625		

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F 0625 SS=E	Continued from page 31 the brain. Review of Resident R30's clinical record revealed that the resident was transferred to the hospital on 2/21/24, and returned to the facility on 2/27/24. Review of Resident R30'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 2/21/24. Review of the clinical record indicated Resident R78 was admitted to the facility on 10/20/23. Review of Resident R78's MDS dated 12/11/24, indicated diagnoses of Alzheimer's Disease, dementia, and malnutrition. Review of Resident R78's clinical record revealed that the resident was transferred to the hospital on 12/1/24, and returned to the facility on 12/5/24.	F 0625		

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F 0625 SS=E	Continued from page 32 Review of Resident R78's clinical record failed to include documented evidence that the resident or the resident's representative were provided with written information about the facility's bed hold policy at the time of the transfer to the hospital on 12/1/24. During an interview on 1/15/25, at 1:05 p.m. the Director of Nursing confirmed that the facility failed to notify the resident or resident's representative of the facility bed-hold policy for Resident R21, R30, and R78. 28 Pa. Code: 201.29(b)(d)(j) Resident rights.	F 0625		
F 0641 SS=D		F 0641		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395986	A. BLDG: 00 B. WING:	01/16/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
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F 0641 SS=D	Continued from page 33 483.20(g) Accuracy of Assessments §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by:	F 0641	Resident # 30 MDS was immediately corrected to accurately reflect resident status. To identify other residents that have the potential to be affected, the MDS/designee completed an audit of current resident to ensure MDS assessments accurately reflect the resident status. Correction will be made as needed. To prevent this from recurring, the RDCS/designee educated MDS/nursing leadership on requirements of F641 and ensuring that resident MDS are updated and accurately reflect resident status. To monitor and maintain ongoing compliance the DON/designee will audit 3 residents weekly x4 then monthly x 2 to ensure resident MDS accurately reflect resident status. Negative findings will be addressed. Ad Hoc education will be provided as needed. The results of the audits will be	Completion Date: **02/11/2025** Status: **APPROVED** Date: **02/07/2025**

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F 0641 SS=D	Continued from page 34	F 0641	forwarded to the facility Quality Assurance Performance Improvement (QAPI) committee for further review and recommendations.	

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 0641 SS=D	Continued from page 35 Based on a review of Resident Assessment Instrument (RAI) User's Manual, clinical records, and staff interviews, it was determined that the facility failed to ensure that MDS assessments accurately reflected the resident's status for one of three residents (Resident R30). Findings include: The Resident Assessment Instrument (RAI) User's Manual, which gives instructions for completing Minimum Data Set (MDS) assessments (mandated assessments of a resident's abilities and care needs), dated October 2024, indicated the following instructions: - O0110K1, Hospice care: code residents identified as being in a hospice program for terminally ill persons where an array of services is provided for the palliation and management of terminal illness and related conditions. Review of the clinical record indicated Resident R30 was admitted to the facility on 1/24/21.	F 0641		

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F 0641 SS=D	Continued from page 36 Review of Resident R30's MDS dated 12/10/24, indicated diagnoses of Alzheimer's Disease (a progressive disease that destroys memory and other important mental functions), dementia (a group of symptoms that affects memory, thinking and interferes with daily life), and senile degeneration of the brain. Review of a physician order dated 3/23/24, indicated to admit Resident R30 to hospice services, effective 3/23/24. Review of Resident R30's Significant Change MDS dated 4/1/24, revealed that Section O0110K1 (Hospice care) was coded "no", indicating that the resident did not receive any hospice care during the 14-day assessment period. During an interview on 1/15/25, at 3:00 p.m. Registered Nurse Assessment Coordinator Employee E2 confirmed that the facility failed to make certain that resident assessments were	F 0641		

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F 0641 SS=D	Continued from page 37 accurate as required. 28 Pa. Code 211.5(f) Clinical records. 28 Pa. Code 211.12(d)(5) Nursing services.	F 0641		
F 0657 SS=D		F 0657		

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 0657 SS=D	Continued from page 38 483.21(b)(2)(i)-(iii) Care Plan Timing and Revision §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by:	F 0657	Resident # 4 Care plan was updated to reflect hospice services. Resident # 4 Care plan was updated to reflect behaviors To identify other residents that have the potential to be affected, the MDS/designee completed an audit of current residents to ensure care plans are updated /revised to reflect current status regarding behaviors and hospice services. To prevent this from recurring, the RDCS/designee educated MDS/nursing leadership on requirements of F657 and ensuring that care plans are updated/revised to reflect the resident's specific care needs To monitor and maintain ongoing compliance the MDS/designee will audit 5 residents weekly x4 then monthly x 2 to ensure care plans are updated/revised to reflect current status for behaviors and hospice service. Negative findings will be addressed. Ad Hoc education will	Completion Date: **02/11/2025** Status: **APPROVED** Date: **02/07/2025**

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 0657 SS=D	Continued from page 39	F 0657	be provided as needed. The results of the audits will be forwarded to the facility Quality Assurance Performance Improvement (QAPI) committee for further review and recommendations.	

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F 0657 SS=D	Continued from page 40 Based on review of facility documents, facility policy, clinical records, and staff interviews, it was determined that the facility failed to ensure that a resident's care plan was updated and revised to reflect the resident's specific care needs for one of four residents (Resident R4). Findings include: Review of facility policy "Comprehensive Care Planning" dated 1/2/24 indicated the resident care conference meets as scheduled to discuss each resident, review the previous care plan and to finalize the development of the current care plan. Adjustments are made by the interdisciplinary team to ensure that all programs and identified category of needs are addressed and that the plan is oriented toward preventing a decline in functioning. Review of the clinical record indicated Resident R4 was admitted to the facility on 4/10/24. Review of Resident R4's Minimum Data Set (MDS	F 0657		

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F 0657 SS=D	Continued from page 41 - a periodic assessment of care needs) dated 10/29/24, indicated diagnoses of high blood pressure, Bipolar Disorder (a mental condition marked by alternating periods of elation and depression), and dementia (a group of symptoms that affects memory, thinking and interferes with daily life). Review of a progress note dated 4/21/24, stated, "Resident (Resident R4) has been exit seeking all shift. Constantly at desk and asking staff how to get out. This writer explained to resident that he cannot leave. Resident walked away from this writer and went down the hall saying "F**k you then." Educated Resident that his language was not appropriate and Resident stated "too bad." Approached desk again and stated to this writer that he needed to leave because "I just came to visit." Educated again that Resident cannot leave the unit. Resident stated "I need to get the f**k out of here." Educated Resident again that his language was not appropriate. Resident walked away from the desk."	F 0657		

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 0657 SS=D	Continued from page 42 Review of a progress note dated 7/31/24, stated, "The D.O.N. (Director of Nursing) was advised by the L.P.N. (Licensed Practical Nurse) on the MIU (Memory Impaired Unit) that the resident (Resident R4) was requesting sexual favors from a female resident. The resident requested fellatio and will be monitored by staff to ensure the safety of other residents who dwell on the MIU. It will be reported to the direct care staff shift to shift of this incident, so all staff have knowledge to monitor this resident's inappropriate behavior." Review of a progress note dated /12/24, stated, "I observed a female resident wheeling her w/c (wheelchair) into this residents (Resident R4) room and when I went to get her the male resident had his hand in his pants. I asked him what he was doing with his hand and he showed me his other hand. I asked him what he had in his other hand and he said his dick, which I knew because he was masturbating with it. I removed the female resident to the dining room and closed his curtain for privacy."	F 0657		

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F 0657 SS=D	Continued from page 43 Review of a progress note dated 12/4/24, stated, "Resident (Resident R4) was being extremely disruptive during the afternoon bingo activity. Staff stated he was upset he ate all of his popcorn quickly and wanted the other residents. When staff said no he said F*** you, suck my dick and was calling her a B****, which upset the group playing bingo at the time." Review of a progress note dated 1/2/25, stated, "Resident (Resident R4) was verbally threatening and raising his fists as if to hit another male resident that wandered in to his room. He was not easily redirected. He is also verbally abusive towards staff calling us obscene names. I was able to get the other male resident away from him without incident." Review of a progress note dated 1/2/25, stated, "Resident (Resident R4) tried to push a female resident to the floor this afternoon. She had got too close to him and pulled on his pant leg. I told him he cannot be pushing other residents and he told me to suck his dick and called me a f***ing whore and a	F 0657		

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F 0657 SS=D	Continued from page 44 F***ing C***. I asked him to please not call staff names and being disrespectful and he continued. I just kept the other resident safe and walked away from him." Review of Resident R4's care plan dated 1/12/25, indicated Resident has verbal and physical behavioral symptoms directed toward others (e.g., threatening others, screaming at others, cursing at others, pushing and combativeness). Review of Resident R4's care plan on 1/13/25, failed to include goals and interventions regarding the resident's verbal and physical behavioral symptoms prior to the care plan developed on 1/12/25. During an interview on 1/16/25, at 5:46 p.m. the Nursing Home Administrator confirmed that the facility failed to ensure a resident's care plan was updated and revised to reflect the resident's specific care needs as required.	F 0657		

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F 0657 SS=D	Continued from page 45 28 Pa. Code 211.5(f) Clinical records. 28 Pa. Code 211.11(a) Resident care plan. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services.	F 0657		
F 0679 SS=D		F 0679		

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F 0679 SS=D	Continued from page 46 483.24(c)(1) Activities Meet Interest/Needs Each Resident §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by:	F 0679	The facility cannot retroactively go back and make corrections for Residents #5 and #52 regarding activities. Moving forward, facility will provide activities to meet the interests of and support the physical, mental, and psychosocial well-being of each resident. To identify residents that have the potential to be affected, Activities Director/designee completed an audit of current resident scheduled events to ensure residents are provided opportunity to engage in group activities. Corrections will be made as needed. To prevent this from recurring, the NHA educated the Activity Director on the Regulatory Requirement of F679 and ensuring activities are provided to meet the interests of and support the physical, mental, and psychosocial well-being of each resident. To prevent this from recurring, the Activity Director is to provide NHA with updated monthly calendar of scheduled events for	Completion Date: **02/11/2025** Status: **APPROVED** Date: **02/07/2025**

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F 0679 SS=D	Continued from page 47	F 0679	next 30 days. To monitor and maintain ongoing compliance the NHA/designee will audit resident events weekly x4 then monthly x 2 to ensure activities meet the interests of and support the physical, mental, and psychosocial well-being of each resident. Negative findings will be addressed. Ad Hoc education will be provided as needed. The results of the audits will be forwarded to the facility Quality Assurance Performance Improvement (QAPI) committee for further review and recommendations.	

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F 0679 SS=D	Continued from page 48 Based on a review of facility policy and documents, resident interviews, and staff interviews, it was determined that the facility failed to provide an ongoing program of activities to meet the interests of and support the physical, mental, and psychosocial well-being of each resident for four of five weeks (12/10/24 through 12/21/24, and 12/26/24 through 1/16/25). Findings include: Review of facility policy "Activities" dated 1/12/25, and previously dated 1/2/24, indicated the facility is to provide an ongoing resident-centered Life Enrichment Program, based on comprehensive assessments and care plans will be provided. The program will be designed to meet the interests (including hobbies and cultural preferences) and the abilities of each resident including as their physical; mental; emotional; social; spiritual; psychosocial and leisure needs. The program will create opportunities for each resident to have a meaningful life by supporting his/her domains of wellness (security,	F 0679		

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F 0679 SS=D	Continued from page 49 autonomy, growth, connectedness, identity, joy, and meaning). The choices, previous positive lifestyles, and daily schedules of each resident will be incorporated. Programs, equipment, and materials will be adapted as necessary. Review of document "COVID-19 (an infectious respiratory disease) Infection Control and Outbreak Response Toolkit for Long-Term-Care, dated February 2024, stated to arrange seating in common areas, treatment areas, and during group activities so that residents are at least six feet apart. Consider scheduling appointments to limit the number of residents in common areas or participating in group activities at one time. During an interview on 1/12/25, at 11:02 a.m. Resident R52 stated "We don't have any activities right now. Everyone is closed up in their rooms". During an interview on 1/12/25, at 11:08 a.m. Resident R5 stated that there are no group activities at this time due to COVID, and added "It's boring".	F 0679		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395986	A. BLDG: 00 B. WING:	01/16/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
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F 0679 SS=D	Continued from page 50 During an interview on 1/15/25, at 10:54 a.m. Infection Preventionist (IP) Employee E1 stated that the facility had a COVID outbreak that began on 11/29/24, and that it had not been lifted. During an interview on 1/16/25, at 10:46 a.m. Activities Director (AD) Employee E7 confirmed that all group activities have been cancelled. "I was told to suspend them with COVID. They closed the Dining Room which limits some activities." AD Employee E7 stated that she was told by the Director of Nursing (DON), and IP Employee E1 to stop group activities on 12/10/25, and to resume them on 12/21/24, and to stop them again on 12/26/24. Group activities currently remain suspended. AD Employee E7 stated that she did not modify any group activities with social distancing or by limiting any group size during this time frame. AD Employee E7 confirmed that the facility failed to provide an ongoing program of activities to meet the interests of and support the physical, mental, and psychosocial well-being of each resident for four of	F 0679		

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F 0679 SS=D	Continued from page 51 five weeks. 28 Pa. Code: 201. 18(b)(3) Management. 28 Pa. Code: 207.2(a) Administrators Responsibility.	F 0679		
F 0684 SS=D		F 0684		

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 0684 SS=D	Continued from page 52 483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by:	F 0684	Resident #199 wound treatment order was immediately clarified and discontinued per physician. Resident #4 wound treatment order was clarified, skin assessment performed, measurements were documented, and physician notified of findings. To identify other residents that have the potential to be affected the DON/designee conducted house audit on all resident wound orders to ensure proper treatment of resident wounds and weekly skin assessments. Any negative findings were addressed. To prevent this from reoccurring, DON/designee educated licensed nursing clinical staff on observation of skin and wound best practices and wound management. To monitor and maintain ongoing compliance the DON/designee will review wound documentation and new wound treatment orders 5x weekly x4 weeks then monthly x2 to	Completion Date: **02/11/2025** Status: **APPROVED** Date: **02/07/2025**

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 0684 SS=D	Continued from page 53	F 0684	ensure appropriate monitoring, documentation and reporting of resident wounds and weekly skin assessments. Negative findings will be addressed. Ad hoc education will be completed as needed. The results of the audits will be forwarded to the facility QAPI committee for further review and recommendations.	

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 0684 SS=D	Continued from page 54 Based on review of facility policy, clinical record review, observations, and staff interviews, it was determined that the facility failed to monitor and ensure proper treatment of resident wounds and complete weekly skin assessments for two of four (Resident R4, and Resident R199). Findings include: Review of facility policy "Skin and Wound Care Best Practices" dated 1/2/24, and last reviewed 1/12/25, indicated the licensed nurses will complete a Weekly Skin Check. This review is in addition to the nursing assistant's shower sheet skin reviews. Review of the clinical record indicated Resident R4 was admitted to the facility on 4/10/24. Review of Resident R4's Minimum Data Set (MDS - a periodic assessment of care needs) dated 10/29/24, indicated diagnoses of high blood pressure, Bipolar Disorder (a mental condition marked by alternating periods of elation and	F 0684		

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 0684 SS=D	Continued from page 55 depression), and dementia (a group of symptoms that affects memory, thinking and interferes with daily life). Review of a progress note dated 4/11/24, indicated Resident R4 was admitted to the facility with a chronic abdominal wound measuring 9 cm (centimeters) x 5 cm. Review of Resident R4's clinical record failed to reveal documentation of the resident's abdominal wound for the week of 9/1/24. Review of Resident R4's clinical record revealed the resident's abdominal wound received a status of "healed" on 9/19/24. Review of a progress note dated 9/24/24, stated, "Resident seen at request of nurse due to concern for abdominal wound opening back up. Resident alert and agreeable to treatment. The two areas that were healed have now opened back up. Each area measures approximately 2 cm x 2 cm. Pink and	F 0684		

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 0684 SS=D	Continued from page 56 moist. Cleaned and dressed with Promogran (a type of dressing that maintains a moist environment and promotes healing) per wound care centers last order. Covered with a dry dressing." Review of Resident R4's clinical record failed to reveal documentation of the resident's abdominal wound for the weeks of 12/22/24, and 12/29/24. During an interview on 1/16/25, at 5:46 p.m. the Nursing Home Administrator confirmed that the facility failed to monitor resident wounds and complete weekly skin assessments as required. Review of Resident R199's admission record indicated the resident was admitted to the facility 11/15/24. A review of Resident R199's MDS dated 12/30/24, included diagnoses of high blood pressure, infection due to cardiac, and vascular device implants, and pressure ulcer of the right buttock, stage 2 (pressure injury with a partial thickness loss of skin presenting	F 0684		

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 0684 SS=D	Continued from page 57 as a shallow open injury with a red/pink wound bed or an intact or open/ruptured serum filled blister). Section M210 stated that Resident R199 had an unhealed pressure injury, and section M1040 stated that he also had a surgical wound. Review of Resident R199's physician order dated 1/8/25, to clean wound bed with wound cleaner, pat dry, apply thin piece of MediHoney alginate (a topical antimicrobial medication for wounds) to wound bed cover with foam dressing. Review of the above order does not indicate what area of the body, or what wound to apply this medication. Review of Resident R199's physician order dated 12/25/24, for Wound VAC (vacuum assisted closure- a device that uses suction to help wounds heal) dressing three times per week. Review of the above order does not indicate what area of the body, or what wound to apply this	F 0684		

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 0684 SS=D	Continued from page 58 treatment. During an interview on 1/15/25 at 4:00 p.m. Registered Nurse Assessment Coordinator (RNAC) Employee E2 confirmed that Resident R199 has two different wounds, but that the facility failed to indicate which treatment should be applied to the surgical wound to ensure proper treatment. 28 Pa. Code 201.18 (b)(1) Management 28 Pa. Code 201.29(d) Resident Rights 28 Pa. Code 211.10 (c)(d) Resident Care policies 28 Pa. Code 211.12 (d)(1)(2)(3)(5) Nursing services	F 0684		
F 0686 SS=D		F 0686		

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 0686 SS=D	Continued from page 59 483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by:	F 0686	Resident #199 wound treatment order was immediately clarified and discontinued per physician. Resident #1 wound treatment order was clarified, skin assessment performed, measurements were documented, and physician notified of findings. To identify other residents that have the potential to be affected the DON/designee conducted house audit on all resident wound orders to ensure proper treatment of resident wounds and weekly skin assessments. Any negative findings were addressed. To prevent this from reoccurring, DON/designee educated licensed nursing clinical staff on observation of skin and wound best practices and wound management. To monitor and maintain ongoing compliance the DON/designee will review wound documentation and new wound treatment orders 5x weekly x4 weeks then monthly x2 to	Completion Date: **02/11/2025** Status: **APPROVED** Date: **02/07/2025**

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F 0686 SS=D	Continued from page 60	F 0686	ensure appropriate monitoring, documentation and reporting of resident wounds and weekly skin assessments. Negative findings will be addressed. Ad hoc education will be completed as needed. The results of the audits will be forwarded to the facility QAPI committee for further review and recommendations.	

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F 0686 SS=D	Continued from page 61 Based on review of facility policy, clinical records, and staff interview, it was determined that the facility failed to make certain that residents received proper treatment and monitoring for pressure ulcers for two of three sampled residents (Residents R1 and R199). The facility "Pressure injury prevention and treatment" policy dated 1/2/24, and last reviewed 1/12/25, indicated that residents will be assessed for pressure injury risk on admission. Monitoring will be at least weekly, and an evaluation of the pressure ulcer/pressure injury will be documented. All assessments will include location/stage, size, pain, wound bed and appearance. Review of Resident R1's admission record indicated she was admitted on 1/6/23. Review of Resident R1's MDS assessment (Minimum Data Set assessment: MDS -a periodic assessment of resident care needs) dated 11/7/24, indicated that she had diagnoses that included	F 0686		

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F 0686 SS=D	Continued from page 62 Peripheral vascular disease (PVD-a progressive narrowing of the blood vessels impacting blood flow to the limbs), diabetes (metabolic disorder impacting organ function related to glucose levels in the human body), pressure ulcers (an injury to the skin and underlying tissue, primarily caused by prolonged pressure on the skin), and anxiety disorder (a medical condition creating a sense of acute fear, restlessness, and worry). The diagnoses were current upon review. The MDS Section M0300B-Unhealed pressure ulcer injury section indicated the number of pressure areas as a "1." Review of Resident R1's care plans dated 10/3/24, indicated to assess the pressure ulcer for stage, size (length, width, and depth), and condition of surrounding skin weekly. Review of Resident R1's physician orders dated 12/24/24, indicated to cleanse left buttock wound. Review of Resident R1's wound assessment dated 12/18/24, indicated that the wound measured 3.0	F 0686		

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F 0686 SS=D	Continued from page 63 cm x 2.8 cm x 0.2 cm. Review of Resident R1's wound assessments, nurse progress notes and physician notes did not include wound assessments for the weeks of 12/25/24 and 1/1/25. During an interview on 1/14/25, at 9:35 a.m. Registered Nurse Employee E3 confirmed that the facility failed to make certain that Resident R1 was monitored and assessed for her pressure ulcers/wounds as required. Review of Resident R199's admission record indicated the resident was admitted to the facility 11/15/24. A review of Resident R199's MDS dated 12/30/24, included diagnoses of high blood pressure, infection due to cardiac, and vascular device implants, and pressure ulcer of the right buttock, stage 2 (pressure injury with a partial thickness loss of skin presenting as a shallow open injury with a red/pink wound bed	F 0686		

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F 0686 SS=D	Continued from page 64 or an intact or open/ruptured serum filled blister). Section M210 stated that Resident R199 had an unhealed pressure injury, and section M1040 stated that he also had a surgical wound. Review of Resident R199's physician order dated 1/8/25, to clean wound bed with wound cleaner, pat dry, apply thin piece of MediHoney alginate (a topical antimicrobial medication for wounds) to wound bed cover with foam dressing. Review of the above order does not indicate what area of the body, or what wound to apply this medication. Review of Resident R199's physician order dated 12/25/24, for Wound VAC (vacuum assisted closure- a device that uses suction to help wounds heal) dressing three times per week. Review of the above order does not indicate what area of the body, or what wound to apply this treatment.	F 0686		

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F 0686 SS=D	Continued from page 65 During an interview on 1/15/25 at 4:00 p.m. Registered Nurse Assessment Coordinator (RNAC) Employee E2 confirmed that Resident R199 has two different wounds, but that the facility failed to indicate which treatment should be applied to the pressure ulcer to ensure proper treatment. 28 Pa. Code 201.18 (b)(1) Management. 28 Pa. Code 211.10 (c)(d) Resident care policies. 28 Pa. Code 211.12 (d)(1)(2)(3)(5) Nursing services.	F 0686		
F 0689 SS=D		F 0689		

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F 0689 SS=D	Continued from page 66 483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by:	F 0689	Resident #52 was assessed for smoking safety awareness and safety accommodations are implemented. To identify other residents that have the potential to be affected, the DON/designee completed an audit of current residents to ensure residents have smoking assessments that reflect current status and reasonable safety accommodations are implemented as needed. Corrections will be made as needed. To prevent this from recurring, the RDCS provided education to licensed nursing on the requirements of completing smoking assessments on the need to implement safety accommodations. To monitor and maintain ongoing compliance the NHA/designee will audit 3 resident weekly x4 then monthly x 2 to ensure smoking assessments are completed per policy to reflect resident current status and that safety	Completion Date: **02/11/2025** Status: **APPROVED** Date: **02/07/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395986	A. BLDG: __00_____ B. WING: _____	01/16/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
KITTANNING HEALTH & REHAB CENTER STATE LICENSE NUMBER: **234802**	**120 KITTANNING CARE DRIVE KITTANNING, PA 16201**

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F 0689 SS=D	Continued from page 67	F 0689	accommodations are implemented as indicated. Negative findings will be addressed. Ad Hoc education will be provided as needed. The results of the audits will be forwarded to the facility Quality Assurance Performance Improvement (QAPI) committee for further review and recommendations.	

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 0689 SS=D	Continued from page 68 Based on review of facility policy, review of facility documentation, resident interview, review of clinical records and staff interview, it was determined that the facility failed to assess residents for smoking safety for one of two residents (Resident R52). Findings include: Review of the facility policy "Resident Smoking" dated 1/12/25, and previously dated 1/2/24, indicated that during the admission process, nursing will ask residents if they smoke or have a desire/intent to smoke while in the facility. Anyone answering yes is further assessed for smoking safety awareness and the need for reasonable physical or safety accommodations. The assessment is completed thereafter on readmission, quarterly, and with any significant change in the resident's condition. Review of the facility "Smoking List," provided on 1/12/25, indicated that Resident R52 was a current smoker.	F 0689		

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F 0689 SS=D	Continued from page 69 Review of clinical record revealed that Resident R52 was originally admitted to the facility on 3/13/21. Review of Resident R52's clinical record indicated that a Smoking Risk form was completed on 10/8/24, that stated that Resident R52 does not smoke and intends to remain non-smoking. Review of Resident R52's MDS (Minimum Data Set, periodic assessment of resident care needs) dated 10/9/25, indicated diagnoses of low potassium in the blood, depression, and nicotine dependence. Section J1300 stated "yes" to current tobacco use. During an interview on 1/14/25 at 10:32 a.m. Resident R52 confirmed that she is a smoker and stated that she goes out to smoke three times a day. During an interview on 1/15/25 at 3:06 p.m. Registered Nurse Assessment Coordinator	F 0689		

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F 0689 SS=D	Continued from page 70 (RNAC) Employee E2 confirmed that Resident R52 is a smoker, and that the facility failed to properly assess Resident R52's smoking risk on 10/8/24. 28 Pa. Code 201.14(a) Responsibility of licensee. 28 Pa. Code 201.18(b)(1)(e)(1) Management. 28 Pa. Code 211.11(d) Resident care policies. 28 Pa. Code 211.12(d)(1)(5) Nursing services.	F 0689		
F 0698 SS=D		F 0698		

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 0698 SS=D	Continued from page 71 483.25(l) Dialysis §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by:	F 0698	Resident #45 was immediately re-weighed, and findings were communicated to the physician. The medication order was reviewed for accuracy and updated as necessary. To identify other residents that have the potential to be affected, the DON/designee reviewed all residents receiving dialysis services to ensure orders are followed, notifications made to physician for weight change and change in condition. Corrections will be made as needed. To prevent this from recurring, the DON/designee educated licensed nurses on regulatory requirements of F698 ensuring residents receiving dialysis services that orders are followed, and notifications made to physician for weight change and change in condition. To monitor and maintain ongoing compliance the DON/designee will audit current residents on dialysis communication binder upon return from dialysis for any new order	Completion Date: **02/11/2025** Status: **APPROVED** Date: **02/07/2025**

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F 0698 SS=D	Continued from page 72	F 0698	recommendations weekly x4 weeks then monthly x2 to ensure orders are followed, and that physician is notified of weight change and changes in condition. Negative findings will be addressed. Ad Hoc education will be provided as needed. The results of the audits will be forwarded to the facility Quality Assurance Performance Improvement (QAPI) committee for further review and recommendations.	

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F 0698 SS=D	Continued from page 73 Based on review of resident clinical records, facility policy and staff interview, it was determined the facility failed ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences for one of one resident receiving hemodialysis (Resident R45). Findings include: A review of the facility "Hemodialysis Care Policy" dated 8/24/23, reviewed 1/12/25, indicated medications will be administered as ordered by the provider. A review of the facility "Resident Change in Condition Policy" dated 6/27/24, indicated the licensed nurse will recognize and intervene in the event of a change in resident condition. The physician will be notified as soon as the nurse identified the change in condition and the resident is stable. The physician must be notified when there is	F 0698		

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F 0698 SS=D	Continued from page 74 a significant change in the resident's physician condition. A review of Resident R45's clinical record indicated the resident was admitted on 4/12/23, and readmitted on 4/24/24. A review of Resident R45's Minimum Data Set (MDS - a periodic assessment of care needs) dated 10/15/24, with the diagnosis of hypertension (high blood pressure) end stage renal disease (last stage of kidney failure) and diabetes (high sugar in the blood). A review of Resident R45's care plan dated 7/17/23, indicated the resident requires Dialysis (a medical procedure that removes waste products of metabolism from the bloodstream when the kidneys are unable to perform that function) and is at risk for fluid volume deficit. Interventions included to follow up with Dialysis book, chart, and record information as noted. Monitor for signs and symptoms of hypovolemia (not enough fluid in body) or	F 0698		

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F 0698 SS=D	Continued from page 75 hypervolemia (too much fluid in the body). It was indicated the resident will maintain fluid balance as evidenced by state/appropriate weight and vital signs. A review of Resident R45's physician orders dated 12/5/23, indicate dialysis Monday, Wednesday, and Friday. Review of Resident R45's clinical record revealed the following: -1/3/24, at 7:45 a.m. 267.3 lbs. entered by Registered Dietary technician, Employee E12 -1/6/24, at 7:44 a.m. 268.8 lbs. entered by Registered Dietary technician, Employee E12 -1/8/25, at 7:43 a.m. 267.9 lbs. entered by Registered Dietary technician, Employee E12 -1/8/25, at 10:21 a.m. 285 lbs. (17.1 lb. weight gain) entered by LPN, Employee E13 -1/10/25, at 9:02 a.m. 285 lbs. entered by LPN, Employee E13 -1/13/25, at 9:08 a.m. 285 lbs. entered by LPN, Employee E13	F 0698		

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F 0698 SS=D	Continued from page 76 A review of Resident R45's progress note dated 1/10/25, entered by Registered Dietary technician, Employee E12 indicated the post dialysis weights obtained from dialysis center from 1/3/25, 1/6/25, and 1/8/25, were entered accordingly. A review of Resident R45's clinical record from 1/8/25, through 1/13/25, failed to include evidence a doctor was notified of Resident R45's 17.1 pound weight gain. During an interview on 1/13/25, at 12:22 p.m. LPN, Employee E13 stated if a resident has a weight gain of greater than five pounds then a doctor must be notified. It was indicated the dietician tracks weight gain and if there is a discrepancy the resident must be reweighed. It was indicated the Registered Nurse is responsible for notifying the physician. LPN, Employee E13 stated the dietician should notify the RN, then the RN contacts the doctor. LPN, Employee E13 confirmed Resident R45's physician was not made aware of Resident R45's change in	F 0698		

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F 0698 SS=D	Continued from page 77 condition. A review of Resident R45's Dialysis communication binder revealed a physician order dated 1/12/25, to administer cinacalcet 120mg on non-dialysis days. A review of Resident R45's physician orders dated 1/13/25, indicated to administer 30 mg cinacalcet with 90 mg cinacalcet on Monday, Wednesday, and Friday after dialysis. The facility failed to enter Resident R45's order for the correct days. During an interview on 1/14/25, at 10:58 a.m. the Director of Nursing confirmed the facility failed to enter Resident R45's medication order from dialysis correctly. The DON confirmed the failed ensure residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences for one of one resident receiving hemodialysis (Resident R45). 28 Pa. Code: §211.5(g)(h) Clinical records.	F 0698		

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F 0698 SS=D	Continued from page 78 28 Pa. Code: §201.14(a)(b)(e)(1)(3) Management. 28 Pa. Code: §211.10(c) Resident care policies. 28 Pa. Code: §211.12(c)(d)(1)(3)(5) Nursing services.	F 0698		
F 0712 SS=D		F 0712		

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F 0712 SS=D	Continued from page 79 483.30(c)(1)-(4) Physician Visits-Frequency/Timeliness/Alt NPP §483.30(c) Frequency of physician visits §483.30(c)(1) The residents must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 thereafter. §483.30(c)(2) A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required. §483.30(c)(3) Except as provided in paragraphs (c)(4) and (f) of this section, all required physician visits must be made by the physician personally. §483.30(c)(4) At the option of the physician, required visits in SNFs, after the initial visit, may alternate between personal visits by the physician and visits by a physician assistant, nurse practitioner or clinical nurse specialist in accordance with paragraph (e) of this section. This REQUIREMENT is not met as evidenced by:	F 0712	Facility cannot retroactively correct and will ensure moving forward that physician visits are conducted at least every 30 days for the first 90 days and then at least every 60 days thereafter. Residents #86 and #201 were immediately evaluated by a physician to ensure facility alleges compliance with regulatory requirement of F712 (Physician Visits –Frequency/Timelines/Alt NPP) To identify other residents that have the potential to be affected, the DON/designee will audit current resident admission assessments to ensure initial admission assessment is completed by a physician within required timeframe and all subsequent physician visits are completed per requirement. Negative findings will be addressed. To prevent this from recurring, the NHA/designee educated Medical Director on initial admission assessment to be completed by a physician within required timeframe and all subsequent physician visits	Completion Date: **02/11/2025** Status: **APPROVED** Date: **02/07/2025**

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F 0712 SS=D	Continued from page 80	F 0712	to be completed per requirement. To monitor and maintain ongoing compliance the DON/designee will audit physician visit assessments weekly x4 then monthly x 2. Negative findings will be addressed. Ad Hoc education will be provided as needed. The results of the audits will be forwarded to the facility Quality Assurance Performance Improvement (QAPI) committee for further review and recommendations.	

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F 0712 SS=D	Continued from page 81 Based on review of clinical records, as well as staff interviews, it was determined that the facility failed to ensure that physician visits were conducted at least every 60 days after the first 90 days of admission for one of nine residents reviewed (Residents R86) and failed to ensure a physician completed the initial visit for one of nine residents (Resident R201). Findings include: Review of Resident R86's clinical record indicated admission to the facility on 2/7/24. Review of Resident R86's Minimum Data Set (MDS - a periodic assessment of care needs) dated 2/13/24, indicated diagnoses of stroke (occurs when the supply of blood to the brain is reduced or blocked completely, which prevents brain tissue from getting oxygen and nutrients.) hypertension (high blood pressure) and dysphagia (difficulty swallowing).	F 0712		

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F 0712 SS=D	Continued from page 82 Review of Resident 86's clinical record revealed there was no documented evidence that Resident R86 was seen by a physician or physician delegate for 232 days between 2/7/24, and 9/25/24. Review of Resident R201's clinical record indicated admission to the facility on 12/17/24. Review of Resident R201's Minimum Data Set (MDS - a periodic assessment of care needs) dated 12/24/24, indicated diagnoses of anxiety, depression, and bipolar disorder (a chronic mood disorder that causes intense shifts in mood, energy levels and behavior). Review of Resident R201's clinical record revealed a new patient visit was completed by Certified Registered Nurse Practitioner, Employee E14 on 12/17/24. The facility failed to ensure the resident's initial visit was conducted by a physician. During an interview on 1/16/25, at 5:36 p.m. the Nursing Home Administrator confirmed the facility	F 0712		

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F 0712 SS=D	Continued from page 83 failed to ensure that physician visits were conducted at least every 60 days after the first 90 days of admission for one of nine residents reviewed (Residents R86) and failed to ensure a physician completed the initial visit for one of nine residents (Resident R201). 28 Pa. Code 211.2(a) Physician Services.	F 0712		
F 0755 SS=D		F 0755		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395986	A. BLDG: 00 B. WING:	01/16/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
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F 0755 SS=D	Continued from page 84 483.45(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	Resident #96 closed record reviewed, and the facility cannot retroactively correct reconciliation of controlled drugs. There were no other concerns identified regarding reconciliation of controlled medications during survey. To identify other residents that have the potential to be affected the DON/designee completed an audit of medication destruction logs for closed records of all residents that discharged at time of exit (1/16/2025 to current) with no negative findings. To prevent this from recurring, the DON/designee educated licensed nursing on medication destruction in compliance with Disposal/Destruction of Expired or Discontinued Medication. To monitor and maintain ongoing compliance the DON/designee will complete medication destruction audit weeklyx4 then monthly x2 to ensure medication	Completion Date: **02/11/2025** Status: **APPROVED** Date: **02/07/2025**

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 0755 SS=D	Continued from page 85 This REQUIREMENT is not met as evidenced by:	F 0755	disposal/destruction and reconciliation is completed appropriately. Negative findings will be addressed. Ad Hoc education will be provided as needed. The results of the audits will be forwarded to the facility Quality Assurance Performance Improvement (QAPI) committee for further review and recommendations.	

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F 0755 SS=D	Continued from page 86 Based on review of facility policy, controlled drug shift count record, and staff interview, it was determined that the facility failed to implement pharmacy procedures for the reconciliation of controlled drugs for one of three closed record residents reviewed (Closed Record (CR) Resident R96). Findings include: Review of facility policy "Disposal/Destruction of Expired or Discontinued Medication" dated 1/2/24, last reviewed 1/12/25, indicated destruction of controlled mediations should be documented on the controlled medication count sheet and signed by the registered nurse and witnessing licensed professional. Discontinued and unused medications of discharged or deceased residents shall be immediately removed from the medication cart and brought to nursing supervisory staff. Review of the clinical record indicated CR Resident R96 was admitted to the facility on 6/21/10.	F 0755		

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F 0755 SS=D	Continued from page 87 Review of CR Resident R6's Minimum Data Set (MDS - a periodic assessment of care needs) dated 11/20/24, indicated diagnoses of Alzheimer's Disease (a progressive disease that destroys memory and other important mental functions), dementia (a group of symptoms that affects memory, thinking and interferes with daily life), and depression (a constant feeling of sadness and loss of interest). Review of a physician order dated 12/18/24, indicated to administer morphine solution 5 mg (milligrams) every four hours as needed for shortness of breath. Review of a progress note dated 12/19/24, stated, "CR Resident R96 CTB (ceased to breathe) at 10:36 a.m. Certified Registered Nurse Practitioner pronounced. Resident Representative notified and is to return call with funeral arrangements." Review of the Controlled Medication Utilization	F 0755		

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F 0755 SS=D	Continued from page 88 Record for CR Resident R96's morphine revealed the documented "Date of Disposition" was 12/22/24, three days after CR Resident R96 had ceased to breathe in the facility. During an interview on 1/16/25, at 12:01 p.m. Regional Director of Clinical Services Employee E5 confirmed that the facility failed to implement pharmacy procedures for the reconciliation of controlled drugs as required. 28 Pa. Code 211.12 (d)(3)(5) Nursing services 28 Pa. Code 211.19(a)(1)(k) Pharmacy services	F 0755		
F 0756 SS=E		F 0756		

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F 0756 SS=E	Continued from page 89 483.45(c)(1)(2)(4)(5) Drug Regimen Review, Report Irregular, Act On §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record.	F 0756	Pharmacy recommendations were reviewed by physician and addressed for Residents #4, #26, and #78. Residents #4, #26 and #78 had no negative outcome. To identify other residents that have the potential to be affected, the DON/designee reviewed pharmacy recommendations from 9/2024 to current (date) to ensure they are reviewed by the physician and addressed timely. Corrections will be made as needed. To prevent this from recurring, the RDCS/designee educated DON/ADON/supervisors on ensuring pharmacy medication regimen reviews and recommendations are reviewed by the physician, addressed and documented timely. To monitor and maintain ongoing compliance the DON/designee will audit pharmacy recommendation weekly x4 then monthly x2 to ensure pharmacy medication regimen	Completion Date: **02/11/2025** Status: **APPROVED** Date: **02/07/2025**

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F 0756 SS=E	Continued from page 90 §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by:	F 0756	reviews and recommendations are reviewed by the physician, addressed and documented timely. Negative findings will be addressed. Ad Hoc education will be provided as needed. The results of the audits will be forwarded to the facility Quality Assurance Performance Improvement (QAPI) committee for further review and recommendations.	

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F 0756 SS=E	Continued from page 91 Based on review of the clinical records and staff interview, it was determined that the facility failed to provide documentation that medication regimen reviews (MRR) were completed for three of three residents reviewed (Resident R4, R26, and R78). Findings include: Review of facility policy "Medication Regimen Review" dated 1/2/24, last reviewed 1/12/25, indicated the consultant pharmacist will provide the resident's MRRs to facility identified personnel who will ensure that the attending physician, medical director, director of nursing and other necessary facility staff receive the recommendations. The attending physician should document in the residents' health record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. The facility should maintain readily available copies of the consultant pharmacists reports on file in the facility, and as part of the resident's permanent health record.	F 0756		

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F 0756 SS=E	Continued from page 92 Review of the clinical record indicated Resident R4 was admitted to the facility on 4/10/24. Review of Resident R4's Minimum Data Set (MDS - a periodic assessment of care needs) dated 10/29/24, indicated diagnoses of high blood pressure, Bipolar Disorder (a mental condition marked by alternating periods of elation and depression), and dementia (a group of symptoms that affects memory, thinking and interferes with daily life). Review of Resident R4's physician orders indicated he was prescribed the following medications: - Ordered on 4/10/24, Trazodone (an antidepressant) 100 mg (milligrams) at bedtime for insomnia - Ordered 4/10/24, Ziprasidone (an antipsychotic) 40 mg at bedtime for Bipolar Disorder Review of a pharmacist progress note dated 12/11/24, stated, "Irregularities/Recommendations noted. See report for any noted irregularities and/or	F 0756		

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F 0756 SS=E	Continued from page 93 recommendations." Review of a pharmacist progress note dated 9/25/24, stated, "Irregularities/Recommendations noted. See report for any noted irregularities and/or recommendations." Review of Resident R4's clinical record on 1/15/25, failed to reveal the consultant pharmacist report for 9/25/24, and 12/11/24. Review of the clinical record indicated Resident R26 was admitted to the facility on 11/25/20. Review of Resident R26's MDS dated 11/23/24, indicated diagnoses of difficulty swallowing, dementia (a group of symptoms that affects memory, thinking and interferes with daily life), and malnutrition (lack of sufficient nutrients to the body). Review of a pharmacist progress note dated 12/12/24, stated, "Irregularities/Recommendations noted. See report for any noted irregularities and/or	F 0756		

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F 0756 SS=E	Continued from page 94 recommendations." Review of Resident R26's physician orders indicated he was prescribed the following medications: -Quetiapine (an antipsychotic) 25 mg twice a day for psychosis Review of Resident R26's clinical record on 1/16/25, failed to reveal the consultant pharmacist report for 12/12/24. Review of the clinical record indicated Resident R78 was admitted to the facility on 10/20/23. Review of Resident R78's MDS dated 12/11/24, indicated diagnoses of Alzheimer's Disease (a progressive disease that destroys memory and other important mental functions), dementia (a group of symptoms that affects memory, thinking and interferes with daily life) and malnutrition (lack of sufficient nutrients to the body).	F 0756		

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F 0756 SS=E	Continued from page 95 Review of Resident R78's physician orders indicated she was prescribed the following medications: - Ordered 12/5/24, Escitalopram (an antidepressant) 10 mg daily - Ordered 12/5/24, Divalproex (an anticonvulsant) 125 mg, give four capsules twice a day - Ordered 12/6/24, Mirtazapine (an antidepressant) 15 mg at bedtime - Ordered 12/5/24, Trazodone 100 mg at bedtime Review of a pharmacist progress note dated 12/6/24, stated, "Irregularities/Recommendations noted. See report for any noted irregularities and/or recommendations." Review of Resident R78's clinical record on 1/15/25, failed to reveal the consultant pharmacist report for 12/6/24. During an interview on 1/16/25, at 11:37 a.m. the Director of Nursing confirmed that the facility was unable to locate and provide documentation that	F 0756		

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F 0756 SS=E	Continued from page 96 medication regimen reviews were completed as required for Resident R4, R26, and R78. 28 Pa Code: 201.14 (a) Responsibility of licensee. 28 Pa. Code 211.5(f) Clinical records. 28 Pa. Code 211.12(c) Nursing services. 28 Pa. Code 211.12(d)(1)(2)(5) Nursing services.	F 0756		
F 0758 SS=D		F 0758		

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F 0758 SS=D	Continued from page 97 483.45(c)(3)(e)(1)-(5) Free from Unnec Psychotropic Meds/PRN Use §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and	F 0758	Residents #4 and #78 had no negative outcome. Diagnosis was clarified by physician and entered into medical record for treatment. To identify other residents that have the potential to be affected, the DON/designee reviewed current residents on psychotropic medications to ensure resident medication regimens are free from unnecessary medications and that there is a diagnosed specific condition for treatment. Corrections will be made as needed. To prevent this from recurring, the RDCS/designee educated licensed nursing on the regulatory requirements of F758 on ensuring resident medication regimens are free from unnecessary medications, that the consult pharmacist report is in the medical record (and addressed) and that there is a diagnosed specific condition for treatment. To monitor and maintain ongoing compliance the DON/designee will	Completion Date: **02/11/2025** Status: **APPROVED** Date: **02/07/2025**

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F 0758 SS=D	Continued from page 98 §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by:	F 0758	review the medical record of 3 residents on psychotropic medications weekly x4 then monthly x2 to ensure resident medication regimens are free from unnecessary medications, that the consult pharmacist report is in the medical record (and addressed) and that there is a diagnosed specific condition for treatment. Negative findings will be addressed. Ad Hoc education will be provided as needed. The results of the audits will be forwarded to the facility Quality Assurance Performance Improvement (QAPI) committee for further review and recommendations.	

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F 0758 SS=D	Continued from page 99 Based on facility policies, clinical record review, and staff interview, it was determined that the facility failed to make certain resident medication regimens were free from potentially unnecessary medications for two of four residents (Residents R4 and R78) and failed to identify a diagnosed specific condition for treatment for one of four residents receiving psychotropic medications (Resident R78). Findings include: Review of facility policy "Psychotropic Medication Use" dated 1/2/24, last reviewed 1/12/25, indicated psychotropic medications are drugs that affect mood, perception, or behavior, and include but are not limited to antipsychotics, anxiolytics, antidepressants, mood stabilizers or hypnotics. Psychotropic medications should only be prescribed to treat specific conditions as diagnosed and documented in the medical record. Review of facility policy "Medication Regimen Review" dated 1/2/24, last reviewed 1/12/25,	F 0758		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395986	A. BLDG: 00 B. WING:	01/16/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
KITTANNING HEALTH & REHAB CENTER STATE LICENSE NUMBER: **234802**	**120 KITTANNING CARE DRIVE** **KITTANNING, PA 16201**

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F 0758 SS=D	Continued from page 100 indicated the consultant pharmacist will provide the resident's MRRs to facility identified personnel who will ensure that the attending physician, medical director, director of nursing and other necessary facility staff receive the recommendations. The attending physician should document in the residents' health record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. The facility should maintain readily available copies of the consultant pharmacists reports on file in the facility, and as part of the resident's permanent health record. Review of the clinical record indicated Resident R4 was admitted to the facility on 4/10/24. Review of Resident R4's Minimum Data Set (MDS - a periodic assessment of care needs) dated 10/29/24, indicated diagnoses of high blood pressure, Bipolar Disorder (a mental condition marked by alternating periods of elation and depression), and dementia (a group of symptoms that affects memory, thinking and interferes with	F 0758		

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F 0758 SS=D	Continued from page 101 daily life). Review of Resident R4's physician orders indicated he was prescribed the following medications: - Ordered on 4/10/24, Trazodone (an antidepressant) 100 mg (milligrams) at bedtime for insomnia - Ordered 4/10/24, Ziprasidone (an antipsychotic) 40 mg at bedtime for Bipolar Disorder Review of a pharmacist progress note dated 12/11/24, stated, "Irregularities/Recommendations noted. See report for any noted irregularities and/or recommendations." Review of a pharmacist progress note dated 9/25/24, stated, "Irregularities/Recommendations noted. See report for any noted irregularities and/or recommendations." Review of Resident R4's clinical record on 1/15/25, failed to reveal the consultant pharmacist report for 9/25/24, and 12/11/24.	F 0758		

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 0758 SS=D	Continued from page 102 Review of the clinical record indicated Resident R78 was admitted to the facility on 10/20/23. Review of Resident R78's MDS dated 12/11/24, indicated diagnoses of Alzheimer's Disease (a progressive disease that destroys memory and other important mental functions), dementia (a group of symptoms that affects memory, thinking and interferes with daily life) and malnutrition (lack of sufficient nutrients to the body). Review of Resident R78's physician orders indicated she was prescribed the following medications: - Ordered 12/5/24, Escitalopram (an antidepressant) 10 mg daily. The physician order failed to identify a specific condition for treatment. - Ordered 12/5/24, Divalproex (an anticonvulsant) 125 mg, give four capsules twice a day. The physician order failed to identify a specific condition for treatment. - Ordered 12/6/24, Mirtazapine (an antidepressant)	F 0758		

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F 0758 SS=D	Continued from page 103 15 mg at bedtime. The physician order failed to identify a specific condition for treatment. - Ordered 12/5/24, Trazodone 100 mg at bedtime. The physician order failed to identify a specific condition for treatment. Review of a pharmacist progress note dated 12/6/24, stated, "Irregularities/Recommendations noted. See report for any noted irregularities and/or recommendations." Review of Resident R78's clinical record on 1/15/25, failed to reveal the consultant pharmacist report for 12/6/24. During an interview on 1/16/25, at 8:50 a.m. the Nursing Home Administrator confirmed that the facility failed to identify a diagnosed specific condition for treatment for psychotropic medication usage for Resident R78 as required. During an interview on 1/16/25, at 11:37 a.m. the Director of Nursing confirmed that the facility was	F 0758		

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F 0758 SS=D	Continued from page 104 unable to locate and provide documentation that medication regimen reviews were completed and that the facility failed to make certain resident medication regimens were free from potentially unnecessary medications as required. 28 Pa Code 211.5(f) Medical records 28 Pa code 211.10(c) Resident care policies 28 Pa. 211.12(c)(d)(1)(3)(5) Nursing services	F 0758		
F 0759 SS=D		F 0759		

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 0759 SS=D	Continued from page 105 483.45(f)(1) Free of Medication Error Rts 5 Prcnt or More §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by:	F 0759	Residents #47 and #24 had no negative outcome. Education was provided to Licensed Nurse Employee #4 and #1. There were no other medication administration concerns identified during survey. To prevent this from recurring, the DON/designee educated licensed nursing on the 5 rights of medication administration and medication availability. To monitor and maintain ongoing compliance the DON/designee will complete medication administration observations with 3 licensed nurses weekly x 4 then monthly x2 to ensure medication administration is completed appropriately. Negative findings will be addressed. Ad Hoc education will be provided as needed. The results of the audits will be forwarded to the facility Quality Assurance Performance	Completion Date: **02/11/2025** Status: **APPROVED** Date: **02/07/2025**

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 0759 SS=D	Continued from page 106	F 0759	Improvement (QAPI) committee for further review and recommendations.	

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 0759 SS=D	Continued from page 107 Based on observation, clinical record review, and staff interview, it was determined that the facility failed to ensure a medication error rate below five percent for two of five residents (Resident R24, and R47). Findings include: The facility's medication error rate was 6.67% (percent) based on 30 medication opportunities with two medication errors. Observation of a medication administration pass on 1/14/25, at 9:40 a.m. revealed Registered Nurse (LPN), Employee E4, failed to administer Resident R47's 305-700mg Potassium phosphate (medication used to make the urine more acidic, preventing kidney stones, as well as odor and rash) timely. Resident R47's medication was scheduled to be administered at 8:00 a.m. LPN, Employee E4 confirmed Resident R47's medication was late. Observation of a medication administration pass on	F 0759		

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 0759 SS=D	Continued from page 108 1/16/25, at 9:26 a.m. revealed LPN, Employee E1, failed to administer Resident R24's Adult 50 Plus 300mcg-250mcg multivitamin. LPN, Employee E15 confirmed the medication was not in stock and not administered as ordered. Interview with the Nursing Home Administrator on 1/16/25, at 6:27 p.m. confirmed the facility failed to ensure a medication error rate below five percent for two of five residents (Resident R24 and R47). 28 Pa. Code 211.10(a) Resident care policies 28 Pa. Code 211.12(d)(1)(5) Nursing services	F 0759		
F 0761 SS=E		F 0761		

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F 0761 SS=E	Continued from page 109 483.45(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 identified items from 2B and Unit 1 Medication Carts, Unit 2 Medication Room items were immediately addressed. R1, R54, and R81s insulin pens were immediately discarded. The DON/designee completed and audit of all medication carts and medications rooms to ensure medications are stored and labelled appropriately. There were no negative findings. To prevent this from recurring, the RDCS/designee educated licensed nursing staff on requirements of F761 and proper storage and labelling. To monitor and maintain ongoing compliance the DON/designee will audit medication carts and medication room/refrigerators weekly x4 then monthly x2 to ensure medications are stored and labelled appropriately. Negative findings will be addressed. Ad Hoc education will be provided as needed.	Completion Date: **02/11/2025** Status: **APPROVED** Date: **02/07/2025**

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F 0761 SS=E	Continued from page 110	F 0761	The results of the audits will be forwarded to the facility Quality Assurance Performance Improvement (QAPI) committee for further review and recommendations.	

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 0761 SS=E	Continued from page 111 Based on observations, and staff interviews, it was determined that the facility failed to properly store medications in two out of two medications carts (2B and Unit 1 Medication Carts) and failed to properly store a medication on one of two medication rooms (Unit Medication Room). Findings include: During an observation on 1/13/25, at 10:16 a.m. of the 2B Medication Cart the following insulin pens failed to be stored correctly: -Resident R1's Insulin Glargine pen (prefilled pen used to help control blood sugar, insulin levels, and digestion) was not stored in a bag. -Resident R54's Insulin Glargine pen was not stored in a bag. -Resident R81's Insulin Glargine pen was not stored in a bag. During an interview on 10/7/24, at 10:22 a.m. Licensed Practical Nurse (LPN) Employee E15 confirmed the facility failed store Resident R1, R54,	F 0761		

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F 0761 SS=E	Continued from page 112 and R81's insulin pen correctly. During an observation on 1/13/25, at 10:23 a.m. Unit one medication cart was observed unlocked and one bottle of 81 milligram (mg) of aspirin and one bottle on Vitamin D3 25 micrograms (mcg) was observed on top of the cart, left unattended. During an observation of Unit 2 Medication Room indicated the following medications and supplies were expired: -(38) Hemoccult (a test is used to check for blood in your bowel movement) Single Slides-Expired 6/30/24 -(1) Box COVID-19 Antigen Home Tests-Expired 11/26/24 -(2) Boxes 30 units/milliliter(ml) Heparin Lock Flushes Expired 8/31/24 -(1) Ace connector with Legacy Connection Expired 10/8/24 During an interview on 1/13/25, at 10:44 a.m.	F 0761		

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F 0761 SS=E	Continued from page 113 Registered Nurse, Employee E3 confirmed the above findings. During an interview on 1/13/25, at 10:50 a.m. the Director of Nursing and Nursing Home Administrator confirmed the facility failed to properly store medications in two out of two medications carts (2B and Unit 1 Medication Carts) and failed to properly store a medication on one of two medications room (Unit Medication Room). 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 0812 SS=F		F 0812		

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F 0812 SS=F	Continued from page 114 483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by:	F 0812	Dietary concerns were addressed immediately during survey. The DM/designee completed a kitchen audit to address any additional findings. To prevent this from recurring, the Dietary Manager /designee will educate the dietary staff on requirements of F812 and ensuring that the food is stored, labelled and dated in kitchen pantries, reach in coolers and freezers. To monitor and maintain ongoing compliance the Dietary manager (DM) will audit kitchen 3x weekly x4 weeks then monthly x2 to ensure food is stored, labelled and dated in kitchen pantries, reach in coolers and freezers. Negative findings will be addressed. Ad Hoc education will be provided as needed. The results of the audits will be forwarded to the facility Quality Assurance Performance Improvement (QAPI) committee for	Completion Date: **02/11/2025** Status: **APPROVED** Date: **02/07/2025**

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 0812 SS=F	Continued from page 115	F 0812	further review and recommendations.	

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 0812 SS=F	Continued from page 116 Based on a review of facility policies, observations and staff interviews it was determined that the facility failed to properly store, label and date food products in the Main Kitchen which created the potential for food borne illness. Findings Include: Review of the facility policy "Storge of Refrigerated Foods" last reviewed 1/12/25, and previously reviewed 1/2/24, indicated that employee lunches shall not be stored in dietary refrigerators. During an observation in the Main Kitchen Back Reach-in Cooler, on 1/12/25, at 9:35 a.m. an opened bottle of Pepsi, and an opened bottle of Dr. Pepper were observed with no name, or date. During an observation in the Main Kitchen Walk-in Freezer, on 1/12/25, at 9:37 a.m. an opened bag of mixed vegetables and an opened package of sausage patties had no date or label.	F 0812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395986	A. BLDG: __00_____ B. WING: _____	01/16/2025

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F 0812 SS=F	Continued from page 117 During an observation in the Main Kitchen Dry Storage, on 1/12/25, at 9:45 a.m. an opened bag of corn flake cereal, had no label or date. During an interview completed on 1/12/24, at 9:55 a.m. Food Service Director Employee E10 confirmed the above observations and that the facility failed to properly store, label, and date food in the Main Kitchen which created the potential for food borne illness. 28 Pa. Code 201.14(a)Responsibility of licensee. 28 Pa. Code 201.18(b)(1) Management. 28 Pa. Code 211.6c Dietary services.	F 0812		
F 0842 SS=E		F 0842		

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 0842 SS=E	Continued from page 118 483.20(f)(5), 483.70(h)(1)-(5) Resident Records - Identifiable Information §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(h) Medical records. §483.70(h)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(h)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;	F 0842	Medications were reviewed for Residents #21, #87, and #199's to ensure medical records were complete and accurately documented to included diagnosis for indication of use for medication. To identify other residents that have the potential to be affected, a house audit was completed by DON/designee to ensure medical records were complete and accurately documented to include diagnosis for indication of use for medication. Corrections will be made as needed. To prevent this from happening again, DON/designee educated licensed nurses on the appropriate documentation of resident diagnosis. To monitor and maintain ongoing compliance the DON /designee will audit new orders weekly x4 then monthly x2 to ensure diagnosis for indication of use are documented in the medical record. Negative	Completion Date: **02/11/2025** Status: **APPROVED** Date: **02/07/2025**

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F 0842 SS=E	Continued from page 119 (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(h)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(h)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.	F 0842	findings will be corrected. Ad Hoc education will be provided as needed. The results of the audits will be forwarded to the facility Quality Assurance Performance Improvement (QAPI) committee for further review and recommendations.	

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F 0842 SS=E	Continued from page 120 This REQUIREMENT is not met as evidenced by:	F 0842		

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F 0842 SS=E	Continued from page 121 Based on review of facility policies and clinical records and staff interview, it was determined that the facility failed to make certain that medical records on each resident are complete and accurately documented for three of four residents (Resident R21, R87, and R199) Findings include: Review of the clinical record indicated Resident R21 was admitted to the facility on 9/14/22. Review of Resident R21's Minimum Data Set (MDS - a periodic assessment of care needs) dated 11/6/24, indicated diagnoses of high blood pressure, hip fracture, and malnutrition (lack of sufficient nutrients to the body). Review of Resident R21's clinical record revealed a physician's order dated 10/31/24, for nifedipine (a drug used to treat high blood pressure or chest pain).	F 0842		

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F 0842 SS=E	Continued from page 122 Review of this order for Resident R21 did not include a diagnosis for use of this drug. Review of Resident R87's admission record indicated the resident was admitted to the facility 11/15/24. A review of Resident R87's MDS dated 11/21/24, included diagnoses of high blood pressure, diabetes (a metabolic disorder in which the body has high sugar levels for prolonged periods of time), and morbid obesity due to excess calories. Review of Resident R87's clinical record revealed a physician's order dated 11/15/24, for gabapentin (a drug used to treat seizures or nerve pain). Review of this order for Resident R87 did not include a diagnosis for use of this drug. Review of Resident R199's admission record indicated the resident was admitted to the facility 8/29/24.	F 0842		

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F 0842 SS=E	Continued from page 123 A review of Resident R199's MDS dated 12/30/24, included diagnoses of high blood pressure, malnutrition, and pressure ulcer of the right buttock, stage 2 (pressure injury with a partial thickness loss of skin presenting as a shallow open injury with a red/pink wound bed or an intact or open/ruptured serum filled blister). Review of Resident R199's clinical record revealed a physician's order dated 12/24/24, for cefazolin (a drug that used to treat various types of infections). Review of this order for Resident R199 did not include a diagnosis for use of this drug. During an interview on 1/15/25 at 3:08 p.m. Registered Nurse Assessment Coordinator (RNAC) Employee E2 confirmed that the facility often fails to select an appropriate diagnosis when entering orders for medications and treatments, which "Can be confusing because some drugs do more than one thing". RNAC Employee E2	F 0842		

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F 0842 SS=E	Continued from page 124 confirmed that the facility failed to make certain that medical records were complete and accurately documented for Resident R21, R87, and R199. 28 Pa. Code: 211.5(f)(g)(h) Clinical records.	F 0842		
F 0849 SS=D		F 0849		

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F 0849 SS=D	Continued from page 125 483.70(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	Resident #46 orders were updated immediately upon discovery during survey. Hospice contact information was obtained and updated in hospice communication binder located at central nurse's station. Moving forward the facility will ensure that diagnosis and order for hospice services are obtained and signed by an ordering physician in accordance with Hospice Care Policy and coordination of hospice services. To identify other like residents, DON/designee will audit current residents on hospice care services to ensure signed physician orders in accordance with Hospice Care Policy and contact information for hospice services. To prevent this from happening again, DON/designee educated licensed nurses and MDS on the appropriate documentation of resident order diagnosis, order for hospice services are obtained and	Completion Date: **02/11/2025** Status: **APPROVED** Date: **02/07/2025**

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F 0849 SS=D	Continued from page 126 (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	signed by an ordering physician in accordance with Hospice Care Policy and ensuring coordination of hospice services with facility services to meet the needs of resident. To monitor and maintain ongoing compliance the DON /designee will audit residents on hospice services weekly x4 then monthly x2 to ensure diagnosis order for hospice services, signed physician order and contact information for hospice services documented in the medical record. Negative findings will be corrected. Ad Hoc education will be provided as needed. The results of the audits will be forwarded to the facility Quality Assurance Performance Improvement (QAPI) committee for further review and recommendations.	

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F 0849 SS=D	Continued from page 127 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		

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F 0849 SS=D	Continued from page 128 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 129 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 130 Based on a review of facility policy, resident clinical records, and staff interview, it was determined the facility failed to obtain a diagnosis, and 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 one of three residents (Resident R46). Findings include: Review of the facility "Hospice Care Policy" dated 5/24/23, and last reviewed 1/12/25, indicated the community provides hospice services through collaboration with a Medicare certified hospice agency when ordered by the resident's physician. Such services will be provided to meet professional standards and be provided timely. The facility will ensure the resident's written plan of care includes both the most recent hospice plan of care and description of the services furnished by the facility to attain and maintain the resident's highest practicable physical, mental, and psychosocial wellbeing. The physician certification and recertification of the	F 0849		

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F 0849 SS=D	Continued from page 131 terminal illness specific to each resident must be obtained from the hospice agency. Review of the clinical record revealed that Resident R46 was admitted to the facility on 8/15/24. Review of Resident 46's MDS (Minimum Data Set-periodic assessment of resident care needs) dated 12/20/24, indicated diagnoses of dementia (the loss of cognitive functioning that interferes with daily life and activities), depression, and anxiety. Section O - Special Treatments, Procedures, and Programs indicated hospice care while a resident. Review of Resident R46's clinical record revealed a physician order dated 12/17/24, indicated to admit to hospice, but did not include a diagnosis related to the need of hospice services, or to admit the resident to hospice services. Review of Resident R46's current comprehensive care plan on 1/14/24, at 1:15 p.m. failed to indicate a plan of care by the facility that displayed the	F 0849		

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	395986	A. BLDG: __00_____ B. WING: _____	01/16/2025

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F 0849 SS=D	Continued from page 132 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. During an interview on 1/15/25, at 2:27 p.m. Registered Nurse Assessment Coordinator Employee E2 confirmed that the facility failed to ensure the coordination of hospice services with facility services to meet the needs of each resident for end-of-life care for Resident R46. Review of Resident R46's hospice communication binder revealed a hospice admission order form dated 12/11/24, that failed to include a physician signature. It was indicated "Medicare regulations require that this form be signed and dated by the physician as soon as possible." During an interview on 1/15/25, at 2:51 p.m. the Nursing Home Administrator and Director of Nursing confirmed the facility failed to obtain a diagnosis, and order for hospice services and to ensure the coordination of hospice services with	F 0849		

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F 0849 SS=D	Continued from page 133 facility services to meet the needs of each resident for end-of-life care for one of three residents (Resident R46). 28 Pa. Code 211.2(a) Physician services 28 Pa. Code 211.11(d) Resident care plan	F 0849		
F 0868 SS=D		F 0868		

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F 0868 SS=D	Continued from page 134 483.75(g)(1)(i)-(iii)(2)(i); 483.80(c) QAA Committee §483.75(g) Quality assessment and assurance. §483.75(g) Quality assessment and assurance. §483.75(g)(1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and (iv) The infection preventionist. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (i) Meet at least quarterly and as needed to coordinate and evaluate activities under the QAPI program, such as identifying issues with respect to which quality assessment and assurance activities, including performance improvement projects required under the QAPI program, are necessary. §483.80(c) Infection preventionist participation on quality assessment and assurance committee. The individual designated as the IP, or at least one of the individuals if there is more than one IP, must be a member	F 0868	All required attendees failed to attend the Quality Assurance Performance Improvement committee meeting. Facility is unable to retroactively correct this citation. Moving forward the facility will maintain Quality Assurance Performance Improvement (QAPI) committee according to the regulation. To prevent this from happening again the RVPO/designee educated the Interdisciplinary Team and Quality Assurance Performance Improvement (QAPI) Committee to ensure the facility's QAPI meeting is occurring quarterly per the regulation and that attendance records are maintained. To monitor and maintain ongoing compliance the RVPO /designee will audit Quarterly x3 to ensure the facility's QAPI meeting is occurring quarterly per the regulation and that attendance records are maintained.	Completion Date: **02/11/2025** Status: **APPROVED** Date: **02/07/2025**

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F 0868 SS=D	Continued from page 135 of the facility's quality assessment and assurance committee and report to the committee on the IPCP on a regular basis. This REQUIREMENT is not met as evidenced by:	F 0868		

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F 0868 SS=D	Continued from page 136 Based on review of facility policy, Quality Assurance attendance records, and staff interview, it was determined that the facility failed to conduct Quality Assessment and Assurance (QAA) meetings at least quarterly with all the required committee members for one of four quarters (January 2024 through March 2024). Findings include: Review of facility policy "Quality Assurance and Performance Improvement (QAPI) Program Policy" dated 1/2/24, last reviewed 1/12/25, indicated the facility will maintain a QAPI Committee consisting, at a minimum of, the Administrator, the Director of Nursing Services, the Medical Director or his/her designee, the designated Infection Preventionist, Direct Care staff on a rotating basis, staff from ancillary departments on a rotating basis, and at least two other members of facility staff. A review of the QAPI Committee meeting sign-in sheets from the period of January 2024 through	F 0868		

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F 0868 SS=D	Continued from page 137 March 2024, did not reveal that the Nursing Home Administrator was in attendance. During an interview on 1/16/25 at 2:08 p.m. the Nursing Home Administrator confirmed that the facility failed to conduct QAA meetings at least quarterly with all the required committee members as required. 28 Pa Code: 201.18(e)(1)(2)(3)(4) Management.	F 0868		
F 0880 SS=L		F 0880		

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F 0880 SS=L	Continued from page 138 483.80(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	1. Infection Control Policies and Procedures were updated and are current as of 16JAN2025 to include guidance related to COVID-19 and Flu from CMS, the Center for Disease Control and PA DOH. 2. To prevent reoccurrence, Infection Preventionist, DON/Designee will conduct routine walking rounds to monitor proper use of personal protective equipment and to ensure infection control procedures are followed in accordance with PA DOH COVID 19 Infection Control and Outbreak Response Toolkit for Long Term Care. 3. The DON/designee will complete education by 11FEB2025 with all staff to include use of personal protective equipment (PPE), prevention, identification, and monitoring of signs and symptoms of COVID-19 and Flu in accordance with PA DOH COVID 19 Infection Control and Outbreak Response Toolkit for Long Term Care.	Completion Date: **02/11/2025** Status: **APPROVED** Date: **02/10/2025**

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F 0880 SS=L	Continued from page 139 (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	4. The DON/designee will complete education by 11FEB2025 with all staff to include proper co-horting protocol, proper social distancing and how to communicate with residents to encourage compliance with guidance related to COVID-19 and Flu PA DOH Infection Control and Outbreak Response Toolkit for Long Term Care. 5. The DON/designee will complete education by 11FEB2025 with all clinical staff on storage and transportation of soiled linens, sharps containers, and biohazard material per facility policy. 6. The DON/Designee will complete education by 11FEB2025 with all clinical staff on proper handwashing procedure, including the use of alcohol-based sanitizers. 7. The DON/Designee will ensure education by 11FEB2025 with all staff on return-to-work guidelines	

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F 0880 SS=L	Continued from page 140	F 0880	related to COVID-19 and Flu PA DOH Infection Control and Outbreak Response Toolkit for Long Term Care. 8.DON/Designee will conduct audits to monitor for completion of Day 1 testing for positive COVID results, daily x 5 days for 14 days, then weekly for 4 weeks then monthly x2. 9.To prevent reoccurrence, DON/Designee will conduct ongoing monitoring for COVID positive staff and monitor return to work status, once a wee x2 weeks, monthly x 2 with outbreak occurrence in accordance with PA DOH COVID 19 Infection Control and Outbreak Response Toolkit for Long Term Care by 1/16/25. 10.To prevent reoccurrence, DON/Designee will conduct ongoing monitoring for Influenza signs and symptoms and testing, weekly with occurrence in accordance with the PA DOH Influenza Outbreak	

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F 0880 SS=L	Continued from page 141	F 0880	Response Toolkit for Long Term Care by 1/16/25. 11.The Infection Preventionist will be assigned CDC Infection Preventionist training in CDC-Train to be completed by 11FEB2025 to enhance awareness and compliance with infection control and prevention protocols. Root Cause(s) 1. Knowledge deficit for Infection Prevention Nurse and DON 2. Performance concerns regarding adhering to guidelines after Education 3. Facility need for evaluation of new Director of Nursing and Assistant Director of Nursing /Infection Prevention nurse Facility removed the Director of Nursing and Infection Prevention Nurse from roles, terminated, and replaced with Interim DON and Interim ADON. The Interim ADON	

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F 0880 SS=L	Continued from page 142	F 0880	will absorb the role of the Infection Prevention Nurse and complete the CDC Infection Preventionist Training in CDC-Train. The facility immediately implemented monitoring, testing and tracking for signs and symptoms of influenza and COVID-19 like symptoms among residents and staff in accordance with the PA DOH COVID-19 Infection Control and Outbreak Response Tool-Kit for Long-Term Care.	

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F 0880 SS=L	Continued from page 143 Based on review of facility policies, documentation, observations, resident and staff interviews and state and federal guidance it was determined that the facility failed to implement COVID and Influenza monitoring, tracking, and testing in accordance with state and federal guidance for 95-101 residents from 11/29/24, through 1/15/25. The facility failed to adhere to state return to work guidance for staff. These failures placed all residents in the facility in an Immediate Jeopardy situation. Review of the facility "Infection Prevention and Control Program Policy" dated 4/16/18, last revised 9/11/23, indicated it is the facility's policy to maintain an organized, effective facility-wide program designed to systemically prevent, identify, control and reduce the risk of acquiring and transmitting infections among employees, volunteers, visitors, and contract healthcare workers, to conduct surveillance of communicable disease and infectious outbreaks, and to monitor employee health. It was indicated employees must follow return to work guidance.	F 0880		

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F 0880 SS=L	Continued from page 144 Review of the Pennsylvania Department of Health Influenza Outbreaks in Long-Term Care Facilities: Toolkit for Facilities dated 2023-2024, and expanded from infection prevention and control guidance from the Centers for Disease Control and Prevention (CDC) for nursing homes and Long-Term Care Facilities revealed the following: -As soon as a respiratory outbreak is suspected, the response should include laboratory testing (i.e., rapid antigen testing, PCR, and/or viral isolation) to evaluate residents and staff and determining the etiology of the outbreak. Specimens should be collected within the first 24-72 hours after symptoms onset and no later than 5 days after symptom onset. -Upon identification of an outbreak, a line listing (designed to collect information about all ill cases for residents and staff during an outbreak of influenza in a long-term care facility) should be utilized to collect and organize information. Information should be	F 0880		

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F 0880 SS=L	Continued from page 145 updated periodically during the outbreak for all cases. -During an outbreak, conduct daily active surveillance for ILI (influenza-like illness-fever greater than 100F plus cough or sore throat) among residents, staff and visitors to the facility until at least one week after the last confirmed influenza case occurred. -All residents and staff with ILI should receive antiviral treatment immediately; treatment should NOT be delayed while waiting for laboratory confirmation. Review of the Pennsylvania Department of Health COVID-19 Infection Control and Outbreak Response Toolkit for Long-Term Care Version 1.1 dated February 2024, and expanded from infection prevention and control guidance from the Centers for Disease Control and Prevention (CDC) for nursing homes and Long-Term Care Facilities revealed the following:	F 0880		

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F 0880 SS=L	Continued from page 146 "During the Outbreak: COVID-19 Outbreak Management and Control Measures" included: -Identify and Isolate First Case. -Identify Additional Cases and Exposures. -Exposed asymptomatic residents and HCP (health care professional) should be tested with a series of up to three viral tests. -Determine approach (contact-tracing, unit-based, facility-based). -Identify exposures because of close contact. -Test exposures immediately (but not within 24 hours of exposure) and if negative, another test at 48 hours, and if negative another test 48 hours later. -Returning to Routine Operations -The facility can return to routine operations when the outbreak has been deemed as complete, which occurs after 14 days without new cases. -Evaluation and Monitoring of Residents	F 0880		

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F 0880 SS=L	Continued from page 147 -It is important to assess for the following symptoms and implement prompt isolation and further evaluation for COVID · Fever or chills · Cough · Shortness of breathe · Fatigue · Muscle or body aches · Headache · New loss of taste or smell · Sore throat · Congestion or runny nose · Nausea or vomiting · Diarrhea -Return to Work Criteria for Healthcare Personnel (HCP) who are NOT moderately to severely immunocompromised · At least seven days have passed since symptoms first appeared; AND a negative antigen (test used to determine current or recent infection) or Nucleic Acid Amplification Test (NAAT-detects one or more	F 0880		

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F 0880 SS=L	Continued from page 148 RNA sequences of SARS-CoV-2 and is considered the gold standard for clinical testing. If someone with prior COVID infection within 90 days, antigen testing is recommended)) is obtained within 48 hours prior to returning to work OR 10 days have passed if testing is not performed or the HCP tests positive at day 5-7; · At least 24 hours have passed since last fever without the use of fever-reducing medications; AND · Symptoms (e.g., cough, shortness of breath) have improved. Review of resident clinical records and facility documents revealed: Review of Resident R11's clinical record indicated an admission date of 12/13/19, and readmitted 12/3/24, with diagnoses of heart failure (occurs when the heart muscle doesn't pump blood as well as it should), myopathy (disorders of the muscles that cause them to function less effectively), and chronic kidney disease (disease that involves a	F 0880		

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F 0880 SS=L	Continued from page 149 gradual loss of kidney function). Review of a report submitted to the Department of Health dated 11/30/24, indicated Resident R11 tested positive for COVID on 11/29/24, while at the hospital. It was indicated as a follow-up action, the facility tested staff prior to the start of their shifts. "The COVID Tool Kit will be followed, and a line listing will be developed for tracking purpose. We will also assess any resident, staff, visitors that would be symptomatic during our COVID testing." Review of the facility's COVID tracking log indicated Resident R11 tested positive at the hospital on 12/3/24. The facility failed to accurately track when the COVID outbreak started. Review of Resident R9's clinical record indicated an admission date of 9/20/23, and readmitted 1/1/25, with diagnoses of Chronic obstructive pulmonary disease (an ongoing lung condition caused by damage to the lungs), high blood pressure, and bipolar disorder (a mental health condition that	F 0880		

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F 0880 SS=L	Continued from page 150 causes extreme mood swings). Review of the facility's COVID tracking log revealed Resident R9 tested positive at the hospital on 12/9/24. Review of the facility documents and resident's clinical records revealed residents tested negative on Day 1, Day 3, and Day 5. The facility failed to provide evidence that all residents were monitored for signs and symptoms of COVID after Day 5 (12/15/24) of testing. Review of the facility documents revealed Nurse Aide, Employee E8 tested positive for COVID on 12/25/24. Review of the facility document titled "COVID Dec/Jan 2025 Contact Tracing" indicated contact tracing was completed for Nurse Aide, Employee E8 and Residents (R5, R6, R8, R9, R12, R13, R21, R26, R27, R33, R38,R43, R44, R47, R52, R53, R57, R62, R68, R70, R73, R87, R92, R94	F 0880		

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F 0880 SS=L	Continued from page 151 R199, R201, R248, R249) were tested on Days 0, 3, and 5 and they were all negative. Review of the facility testing log revealed the facility failed to test residents on Day 1, 12/26/24. Review of the facility documents revealed Infection Preventionist, Employee E1 tested positive for COVID on 1/8/25. During an observation on 1/14/25, at 11:30 a.m. the signage posted at the facility's entrance stated if staff test positive for a respiratory illness (COVID, Flu, RSV) in the last 10 days, do not enter resident care areas. It was indicated to wait 10 days after the date of the positive test, symptom onset, or exposure "to return work". During an interview on 1/14/25, at 12:52 p.m. Infection Preventionist, Employee E1 stated during a COVID outbreak residents are tested on Day 0, 1, 3, and 5. IP, Employee E1 stated if staff members are positive for COVID, they can return to work on the 5th day if they test negative. IP, Employee E1	F 0880		

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F 0880 SS=L	Continued from page 152 confirmed she tested positive for COVID on 1/8/25, and returned to work on 1/13/25. IP, Employee E1 confirmed she failed to wait at least seven days since symptoms first appeared and test negative 48 hours prior to returning to work or wait at least 10 days since she tested positive to return to work. During an interview on 1/14/25, at 1:26 p.m. the NHA and Regional Director of Clinical Services, Employee E5 confirmed Infection Preventionist, Employee E1 failed adhere to return to work guidelines. During an interview on 1/15/25, at 10:54 a.m. IP, Employee E1, NHA, and RDCS, Employee E5 confirmed the facility failed to accurately track, test, and monitor resident's during the COVID outbreak. Review of Resident R9's clinical record indicated on 1/3/25, Resident R9 was ordered Guaifenesin (medication used for cough) for a cough. Review of clinical record failed to indicate he was monitored	F 0880		

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F 0880 SS=L	Continued from page 153 for ILI symptoms or tested for Influenza. Review of Resident R9's progress note dated 1/5/25, indicated Resident R9 requested Robitussin (medication used for cough) for his cough. Review of Resident R9's progress note dated 1/10/25, at 5:15 p.m. indicated Resident R9 was demanding to have an ambulance called to be taken to the Emergency Room for cold symptoms. The facility staff informed him that the ER is for life-threatening emergencies and that his cold could be treated in house. Resident R9 then requested a breathing treatment. Review of Resident R9's progress note dated 1/11/25, indicated he was sent out to the hospital for behaviors. The resident tested positive for Influenza A at the hospital. Review of Resident R27's clinical record indicated an admission date of 11/27/24, with diagnoses of heart failure, intellectual disabilities (a condition that	F 0880		

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F 0880 SS=L	Continued from page 154 limits intelligence and disrupts abilities necessary for living independently), and pneumonia (infection that affects the lungs). Review of Resident R27's progress note dated 1/6/25, indicated the resident complained of stomach pain and hyperemesis (severe nausea and vomiting) that was dark green in color. Resident R27 was sent to the hospital for further evaluation. The facility failed to assess the resident for ILI symptoms and test for Influenza. Review of Resident R27's progress note dated 1/7/25, indicated on 1/6/25, the resident returned to the facility and was diagnosed with Influenza A. Review of Resident R52's clinical record indicated an admission date of 3/13/21, and readmitted 1/8/25, with diagnoses of depression, anemia (a problem of not having enough healthy red blood cells or hemoglobin to carry oxygen to the body's tissues), and dorsalgia (back pain).	F 0880		

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F 0880 SS=L	Continued from page 155 Review of Resident R52's progress note dated 1/7/25, indicated the resident went to the hospital for a CT scan. RN, Employee E3 received a call from the emergency room that indicated while the resident was at her appointment she became short of breath and had a cough. She was taken to emergency room and tested positive for Influenza A. During an interview on 1/15/25, at 10:48 a.m. Resident R52 stated "I was sick for a couple of days before the hospital with nausea and coughing, I don't think they gave me anything for it. I told the nurses I didn't feel well, I had an appointment out of the building and the doctor sent me to ER and that's when they tested me for flu." Review of Resident R52's clinical record failed to indicate the facility assessed the resident for ILI symptoms and test for influenza. Review of Resident R42's clinical record indicated an admission date of 1/10/22, and readmitted 3/29/24, with diagnoses of heart failure, hypoxemia	F 0880		

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F 0880 SS=L	Continued from page 156 (low levels of oxygen in your blood, and anemia. Review of Resident R42's progress note dated 1/11/25, at 9:45 a.m. indicated the resident had fever of 102.5 Fahrenheit, audible wheezing, and oxygen saturation was 78% on room air. The facility failed to conduct Influenza testing. Review of Resident R42's progress note dated 1/11/25, at 2:15 p.m. indicated the resident was transferred to the hospital and tested positive for Influenza. Review of facility's "Flu Jan 2025" line listing report for Influenza, revealed Resident R27 tested positive for Influenza A on 1/6/25. Resident R52 tested positive on 1/7/25. The last reported positive cases were on 1/11/25 (Resident R9, R42, and Housekeeper, Employee E9.) The facility was in an Influenza outbreak as of 1/11/25. During an observation on 1/14/25, at 11:30 a.m. the signage posted at the facility's entrance failed to	F 0880		

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F 0880 SS=L	Continued from page 157 indicate the facility was in an Influenza outbreak. During an interview on 1/14/25, at 11:32 a.m. the Nursing Home Administrator confirmed the signage posted at the entrance of the facility failed to indicate the facility was in an Influenza outbreak. During an interview on 1/14/25, at 12:58 p.m. IP, Employee E1 stated Resident R27 was sent to the hospital and tested positive for Influenza on 1/6/24. IP, Employee E1 confirmed Resident R52 was sent out for routine visit and was transferred to hospital for a change in condition and tested positive for Influenza. IP, Employee E1 stated "we didn't know she had flu until we sent her" and stated she was aware she had respiratory symptoms the whole week prior to sending her out to her appointment. IP, Employee E1 stated she would only test for Influenza if the physician was notified, and it was ordered. IP, Employee E1 confirmed the facility failed to monitor residents for ILI symptoms during an Influenza outbreak and test 4 of 4 Residents who had signs and symptoms of Influenza (Resident R9,	F 0880		

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F 0880 SS=L	Continued from page 158 R27, R42, and R52). During an interview on 1/15/25, at 11:07 a.m. the NHA and RDCS, Employee E5 confirmed the facility failed to test four of four residents for Influenza who had symptoms (Resident R9, R27, R42, and R52). The NHA confirmed no residents were tested for Influenza in the facility. During an interview on 1/15/25, at 2:49 p.m. the Nursing Home Administrator (NHA), Director of Nursing (DON), and RCDS Employee E5 were made aware that an Immediate Jeopardy (IJ) existed. The NHA was provided the IJ Template and at that time a corrective action plan was requested. On 1/15/25, at 5:47 p.m. an acceptable Corrective Action Plan was received, which included the following interventions: Issue #1 -Facility immediately initiated monitoring signs and symptoms for residents with COVID.	F 0880		

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F 0880 SS=L	Continued from page 159 IP/Designee will conduct house audit of residents with signs and symptoms of COVID by EOD 1/16/25. -Regional Director of Clinical Services will conduct in-service regarding Infection Control and Outbreak Response to facility Infection Preventionist and Director of Nursing by 1/16/25. -IP/Designee will conduct education to all staff regarding infection control measures and monitoring at their start of shift beginning 1/15/25 and before next shift by EOD 1/16/25. -To prevent reoccurrence, DON/Designee will conduct audits to monitor for resident's signs and symptoms for COVID, daily x5 days for 14 days , then weekly for 4 weeks then monthly x2. -Negative findings will be addressed. Policies and Procedures to be reviewed and updated as needed. Ad hoc education will be provided as needed. The results of the audits will be forwarded to the facility Quality Assurance Performance Improvement (QAPI) committee for further review and recommendations.	F 0880		

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F 0880 SS=L	Continued from page 160 Issue #2 -Effective 1/15/25, facility will ensure that COVID testing occurs on Day 1 following a positive result in accordance with PA DOH COVID 19 Infection Control Outbreak Response Toolkit for Long Term Care. -IP/Designees will conduct house audit of all COVID testing to ensure Day 1 testing complete upon positive result by EOD 1/16/25. -Regional Director of Clinical Services will conduct in-service regarding Infection Control and Outbreak Response testing procedures to facility Infection Preventionist and Director of Nursing by 1/16/25. -IP/Designee will conduct education to all staff regarding Infection Control and Outbreak Response testing procedures at their start of beginning 1/15/2025 and before next shift by EOD 1/16/25. -To prevent reoccurrence, DON/Designee will conduct audits to monitor for completion of Day 1 testing for positive COVID results, daily x5 days for 14 days , then weekly for 4 weeks then monthly x2. -Negative findings will be addressed. Policies and Procedures to be reviewed and updated as needed.	F 0880		

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F 0880 SS=L	Continued from page 161 Ad Hoc education will be provided as needed. The results of the audits will be forwarded to the facility Quality Assurance Performance Improvement (QAPI) committee for further review and recommendations. Issue #3 -Effective 1/15/25, facility will ensure that return to work guidance for a staff member who tested Outbreak Response Toolkit for Long Term Care. -IP/Designee will monitor for any COVID positive staff weekly x4 weeks, monthly x2 months, and ongoing with occurrence, to ensure that return to work guidance for a staff member who tested positive for COVID is followed. -IP/Designee will conduct education regarding return to work guidance for a staff member who tested positive for COVID is followed in accordance with PA DOH COVID 19 Infection Control and Outbreak Response Toolkit for Long Term Care beginning 1/15/2025 and before next shift by EOD 1/16/25. -To prevent reoccurrence, DON/Designee will	F 0880		

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F 0880 SS=L	Continued from page 162 conduct ongoing monitoring for COVID positive staff and monitor return to work status, weekly with outbreak occurrence in accordance with PA DOH COVID 19 Infection Control and Outbreak Response Toolkit for Long Term Care by 1/16/25. -Negative findings will be addressed. Policies and Procedures to be reviewed and updated as needed. Ad Hoc education will be provided as needed. The results of the audits will be forwarded to the facility Quality Assurance Performance Improvement (QAPI) committee for further review and recommendations. Issue #4 -Effective 1/15/2025, IP/Designee to ensure that residents exhibiting signs and symptoms of Influenza are monitored in accordance with the PA DOH Influenza Outbreak Response Toolkit for Long Term Care. -IP/Designee will monitor all residents weekly x 4 weeks, monthly x 2 months and ongoing with occurrence for any sign and symptoms of Influenza in accordance with the PA DOH Influenza	F 0880		

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F 0880 SS=L	Continued from page 163 Outbreak Response Toolkit for Long Term Care. -Regional Director of Clinical Services will conduct Inservice regarding identification of Influenza signs and symptoms and testing in accordance with the PA DOH Influenza Outbreak Response Toolkit for Long Term Care by 1/16/25. -IP/Designee will conduct education to all staff regarding identification of Influenza signs and symptoms and testing in accordance with the PA DOH Influenza Outbreak Response Toolkit for Long Term Care beginning 1/15/2025 and before next shift by EOD 1/16/25. -To prevent reoccurrence, DON/Designee will conduct ongoing monitoring for Influenza signs and symptoms and testing, weekly with occurrence in accordance with the PA DOH Influenza Outbreak Response Toolkit for Long Term Care by 1/16/25. -Negative findings will be addressed. Policies and Procedures to be reviewed and updated as needed. Ad Hoc education will be provided as needed. The results of the audits will be forwarded to the facility Quality Assurance Performance Improvement (QAPI) committee for further review	F 0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395986	A. BLDG: __00_____ B. WING: _____	01/16/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
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F 0880 SS=L	Continued from page 164 and recommendations. Issue #5 -Effective 1/15/2025, IP/Designee will conduct an initial audit of all residents ' temperatures to ensure that residents exhibiting signs and symptoms of Influenza are monitored in accordance with the PA DOH Influenza Outbreak Response Toolkit for Long Term Care. -IP/Designee will monitor all residents ' temperatures weekly x 4 weeks, monthly x 2 months and ongoing with occurrence for any sign and symptoms of Influenza in accordance with the PA DOH Influenza Outbreak Response Toolkit for Long Term Care. -Regional Director of Clinical Services will conduct Inservice regarding identification of Influenza signs and symptoms and monitoring in accordance with the PA DOH Influenza Outbreak Response Toolkit for Long Term Care by 1/16/25. -IP/Designee will conduct education to all staff regarding identification of Influenza signs and symptoms and monitoring in accordance with the	F 0880		

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F 0880 SS=L	Continued from page 165 PA DOH Influenza Outbreak Response Toolkit for Long Term Care beginning 1/15/25 and before next shift by EOD 1/16/25. -To prevent reoccurrence, DON/Designee will conduct ongoing monitoring for Influenza signs and symptoms, weekly with occurrence in accordance with the PA DOH Influenza Outbreak Response Toolkit for Long Term Care by 1/16/2025. -Negative findings will be addressed. Policies and Procedures to be reviewed and updated as needed. Ad Hoc education will be provided as needed. The results of the audits will be forwarded to the facility Quality Assurance Performance Improvement (QAPI) committee for further review and recommendations. Review of medical records and facility documents on 1/16/25, revealed 98 of 98 residents were assessed for signs and symptoms of Influenza and COVID. No residents exhibited IFI symptoms and required Influenza testing. The facility obtained Influenza tests from hospital and were available for staff to use if needed. Facility wide testing was	F 0880		

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F 0880 SS=L	Continued from page 166 conducted on all residents and staff prior to the start of their shift for COVID. The DON completed an audit of tests and no positive COVID results were identified. The facility will conduct COVID testing until Day 5, then monitor residents and staff for signs and symptoms of COVID, and test as needed, until Day 14. Review of facility documents revealed the policy for Managing respiratory Illnesses and Outbreaks and Investigating Communicable Outbreaks was created 1/16/25. During an observation on 1/16/25, at 9:02 a.m. the signage posted at the entrance of the facility indicated the facility was currently in an influenza and COVID outbreak. Review of facility documents on 1/16/25, revealed the Regional Director of Clinical Services, Employee E5 conducted an in-service with the Infection Preventionist, Employee E1, and the Director of Nursing on 1/15/25.	F 0880		

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F 0880 SS=L	Continued from page 167 Review of facility documents on 1/16/25, revealed that the facility had 104 employees and 100% had received education on the facility's COVID-19 and Influenza infection control practices and outbreak response. 48 of these employees received formal education on the facility's COVID-19 infection control practices. 56 of these employees had received this education via telephone as they had not been working in the building. Staff are to sign that they received this education when they are in the building before the start of their next shift. During staff interviews conducted on 1/16/25, between 2:45 p.m. and 3:02 p.m. 28 employees confirmed that they received education on the facility's COVID-19 and Influenza infection control practices and outbreak response. 21 of these employees had received education in person and seven of these employees had received education over the telephone and signed the training sheet prior to the start of their shift.	F 0880		

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F 0880 SS=L	Continued from page 168 The Immediate Jeopardy was lifted on 1/16/25, at 5:49 p.m. when the action plan implementation was verified. During an interview on 1/16/25, at 6:39 p.m. the Nursing Home Administrator confirmed that the facility failed to implement COVID and Influenza monitoring, tracking, and testing in accordance with state and federal guidance for 95-101 residents from 11/29/24, through 1/15/25. The facility failed to adhere to state return to work guidance for staff. These failures placed all residents in the facility in an Immediate Jeopardy situation. 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		

Pennsylvania Department of Health

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H 0009		H 0009		

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

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H 0009	Continued from page 1 51.3 (g)(1-14) NOTIFICATION 51.3 Notification (g) For purposes of subsections (e) and (f), events which seriously compromise quality assurance and patient safety include, but not limited to the following: (1) Deaths due to injuries, suicide or unusual circumstances. (2) Deaths due to malnutrition, dehydration or sepsis. (3) Deaths or serious injuries due to a medication error. (4) Elopements. (5) Transfers to a hospital as a result of injuries or accidents. (6) Complaints of patient abuse, whether or not confirmed by the facility. (7) Rape. (8) Surgery performed on the wrong patient or on the wrong body part. (9) Hemolytic transfusion reaction. (10) Infant abduction or infant discharged to the wrong family. (11) Significant disruption of services due to disaster such as fire, storm, flood or other occurrence.	H 0009	The facility cannot retroactively go back and make corrections. Moving forward, the facility will report allegations of resident-to-resident abuse in the required timeframe. To identify other residents that have the potential to be affected, the DON/designee reviewed progress notes from date of exit (1/16/2025 to current) to ensure those occurrences that meet the requirement are reported timely. Corrections will be made as needed. To prevent this from recurring, the RDCS provided education to the NHA and DON on the regulatory requirements of F609 and timely reporting of resident-to-resident abuse. To monitor and maintain ongoing compliance the NHA/designee will audit resident events weekly x4 then monthly x 2 to ensure those occurrences that meet the requirement are reported timely.	Completion Date: **02/11/2025** Status: **APPROVED** Date: **02/10/2025**

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H 0009	Continued from page 2 (12) Notification of termination of any services vital to continued safe operation of the facility or the health and safety of its patients and personnel, including, but not limited to, the anticipated or actual termination of electric, gas, steam heat, water, sewer and local exchange of telephone service. (13) Unlicensed practice of a regulated profession. (14) Receipt of a strike notice. This REGULATION is not met as evidenced by:	H 0009	Negative findings will be addressed. Ad Hoc education will be provided as needed. The results of the audits will be forwarded to the facility Quality Assurance Performance Improvement (QAPI) committee for further review and recommendations. The ERS event was submitted-#1070952	

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H 0009	Continued from page 3 Based on policy review, resident clinical record, and staff interview, it was determined that the facility failed to notify the local State Agency of an incident involving a fall and hospitalization for one of three residents (Resident R48). Findings include: Review of Resident R48's admission record indicated that he was admitted on 1/14/24. Review of Resident R48's MDS assessment (Minimum Data Set assessment: MDS -a periodic assessment of resident care needs) dated 11/12/24, indicated that he had diagnoses that included Parkinson's disease (a disorder of the central nervous system which affects movement and includes tremors), anxiety disorder (a medical condition creating a sense of acute fear, restlessness, and worry), seizure disorder (a disorder of the brain characterized by repeated seizures), and lack of coordination. The diagnoses were current upon review.	H 0009		

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H 0009	Continued from page 4 Review of Resident R48's clinical nurse progress note dated 11/22/24, indicated that at 2:00 a.m. staff was called to assess Resident R48 after report that he pulled out his G-tube at 0130. Upon inspection Resident R48 was lying on his bed and the abdomen area was cleaned and bandaged without obvious signs of trauma. The tube with balloon is intact. Resident R48 was angry and swinging his arms around making it difficult to attempt re-insertion. Doctor was notified and gave order to send resident to Emergency Room for re-insert. According to staff, one half hour prior to incident, Resident R48 woke up screaming, unable to self soothe or be soothed by staff. Brief was changed and he was helped into w/c (wheelchair) and taken to nurse's station for monitoring. At the nurse's station the screaming continued so resident was wheeled back into his room. Immediately upon entering into his room, he threw himself out of his wheelchair onto floor and yanked out his G-tube. Spoke to brother over the phone and made him aware of incident and resident left with EMS	H 0009		

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H 0009	Continued from page 5 (emergency medical services) at 2:00 a.m. Review of events submitted to the state did not include a notification to the local state field office of Resident R48's hospitalization. During an interview 1/13/25, at 1:30 p.m. the Director of Nursing (DON) the facility failed to notify the local State Agency of an incident involving a fall and hospitalization for Resident R48 as required.	H 0009		

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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	All required attendees failed to attend the Infection Control Committee meetings. Facility is unable to retroactively correct this citation. From the date of exit (1/16/2025) forward the facility will maintain Infection Control Committee attendance requirements according to the regulation. To prevent this from happening again the RVPO/designee educated the Interdisciplinary Team and Quality Assurance Performance Improvement (QAPI) Committee to ensure the facility's QAPI meeting is occurring quarterly per the regulation and that attendance records are maintained. To monitor and maintain ongoing compliance the RVPO /designee will audit Quarterly x3 to ensure the facility's QAPI meeting is occurring quarterly per the regulation and that attendance records are maintained.	Completion Date: **02/11/2025** Status: **APPROVED** Date: **02/07/2025**

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P 1020	Continued from page 1 Based on state regulations, staff interview, and review of the facility's Infection Control Meeting attendance records, it was determined that the facility failed to ensure that all the required nine multidisciplinary members were present at the Infection Control Meetings (a member from the community) for one of four quarters (Quarter 4). 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 include medical staff, administration, laboratory personnel, nursing staff, pharmacy staff, physical plan personnel, patient	P 1020		

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P 1020	Continued from page 2 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 (October 2024, November 2024, December 2024), failed to reveal that a member from the community was in attendance. During an interview on 1/16/25, at 2:02 p.m. the Nursing Home Administrator confirmed that the facility failed to ensure that all the required nine multidisciplinary members were present at the Infection Control Meetings for one of four quarters.	P 1020		
P 5520		P 5520		

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P 5520	Continued from page 3 Nursing services. (3) Effective July 1, 2024, a minimum of 1 nurse aide per 10 residents during the day, 1 nurse aide per 11 residents during the evening, and 1 nurse aide per 15 residents overnight. This REGULATION is not met as evidenced by:	P 5520	The facility will continue to maintain the required nurse aide ratio of 1-10; 1-11; and 1-15. To increase staffing facility will calling in off duty staff, calling sister facilities or utilizing agency as needed, acquire new agency partnership, offer bonuses to current staff to ensure sufficient nursing staffing. The RDCS educated NHA/DON/scheduler on the required 1-10; 1-11; and 1-15 nurse aide ratio requirements ensuring sufficient nursing staff. To monitor and maintain ongoing compliance the NHA/DON/scheduler will complete staffing meetings 2x daily x 5x weekly x4 weeks then 1x daily x5 x weekly ongoing thereafter to ensure sufficient nursing staff. The results of the audits will be forwarded to the facility Quality Assurance Performance	Completion Date: **02/11/2025** Status: **APPROVED** Date: **02/10/2025**

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P 5520	Continued from page 4	P 5520	Improvement (QAPI) committee for further review and recommendations.	

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P 5520	Continued from page 5 Based on review of nursing time schedules and staff interviews, it was determined that the facility administrative staff failed to provide a minimum of one nurse aide (NA) per 10 residents during the day shift for 13 of 21 days (12/22/24, 12/23/24, 12/24/24, 12/26/24, 12/27/24, 12/28/24, 12/29/24, 1/3/25, 1/4/25, 1/10/25, 1/11/25, 1/13/25, and 1/14/25), one nurse aide per 11 residents on evening shift for 17 of 21 days (12/22/24, 12/23/24, 12/24/24, 12/25/24, 12/26/24, 12/30/24, 12/31/24, 1/1/25, 1/2/25, 1/3/25, 1/4/25, 1/9/25, 1/10/25, 1/11/25, 1/13/25, 1/14/25, and 1/15/25), and one nurse aide per 15 residents on night shift, on four of 21 days (12/25/24, 12/29/24, 1/12/25, and 1/15/25). Findings include: Review of facility census data and nursing time schedules from 12/22/24 through 12/28/24, 12/29/24 through 1/4/25, and 1/9/25 through 1/15/25 revealed the following NA staffing shortages.	P 5520		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395986	A. BLDG: 00 B. WING:	01/16/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
KITTANNING HEALTH & REHAB CENTER STATE LICENSE NUMBER: **234802**	**120 KITTANNING CARE DRIVE** **KITTANNING, PA 16201**

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P 5520	Continued from page 6	P 5520		

Day Shift:

Date	Census	Full Time Equivalents (FTE) Present	FTE Required
12/22/24	98	8.53	9.80
12/23/24	97	8.53	9.70
12/24/24	98	9.60	9.80
12/26/24	98	9.60	9.80
12/27/24	99	8.53	9.90
12/28/24	98	9.60	9.80
12/29/24	99	8.53	9.90
1/3/25	96	8.53	9.60
1/4/25	99	9.07	9.60
1/10/25	97	9.60	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395986	A. BLDG: 00 B. WING:	01/16/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
KITTANNING HEALTH & REHAB CENTER STATE LICENSE NUMBER: **234802**	**120 KITTANNING CARE DRIVE KITTANNING, PA 16201**

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P 5520	Continued from page 7	P 5520		

9.70
1/11/25 96 8.53
9.60
1/13/25 95 8.53
9.50
1/14/25 95 9.07
9.50

Evening Shift:

Date	Census	FTE Present	FTE Required
12/22/24	98	8.00	8.91
12/23/24	97	7.47	8.82
12/24/24	98	8.53	8.91
12/25/24	98	7.73	8.91
12/26/24	98	8.80	8.91
12/30/24	99	8.53	9.00
12/31/24	98	8.53	8.91
1/1/25	98	8.53	8.91
1/2/25	97	8.00	8.82
1/3/25	96	8.27	8.73
1/4/25	96	8.53	8.73
1/9/25	97	8.53	8.82

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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P 5520	Continued from page 8	P 5520		

1/10/25	97	8.00	8.82
1/11/25	96	8.53	8.73
1/13/25	95	7.47	8.64
1/14/25	95	8.00	8.64
1/15/25	98	8.53	8.91

Night Shift:

Date	Census	FTE Present	FTE Required
12/25/24	98	6.40	6.53
12/29/24	99	6.40	6.60
1/12/25	96	5.87	6.40
1/15/25	98	6.40	6.53

During an interview on 1/16/25, at 3:08 p.m. the Nursing Home Administrator confirmed that the facility failed to provide a minimum of one nurse aide per 10 residents during the day shift, one nurse aide per 11 residents on evening shift, and one nurse aide per 15 residents on night shift as required with no additional excess higher-level staff to compensate this deficiency.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395986	A. BLDG: 00 B. WING:	01/16/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
KITTANNING HEALTH & REHAB CENTER STATE LICENSE NUMBER: **234802**	**120 KITTANNING CARE DRIVE KITTANNING, PA 16201**

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P 5530	Nursing services. (4) Effective July 1, 2023, a minimum of 1 LPN per 25 residents during the day, 1 LPN per 30 residents during the evening, and 1 LPN per 40 residents overnight. This REGULATION is not met as evidenced by:	P 5530	The facility will continue to maintain the required LPN ratios (1-25, 1-30, 1-40). To increase staffing facility will calling in off duty staff, calling sister facilities or utilizing agency as needed, acquire new agency partnership, offer bonuses to current staff to ensure sufficient nursing staffing. The RDCS educated NHA/DON/scheduler on the LPN ratio requirements ensuring sufficient nursing staff (1-25, 1-30, 1-40). To monitor and maintain ongoing compliance the NHA/DON/scheduler will complete staffing meetings 2x daily x 5x weekly x4 weeks then 1x daily x5 x weekly ongoing thereafter to ensure sufficient nursing staff. The results of the audits will be forwarded to the facility Quality Assurance Performance Improvement (QAPI) committee for further review and recommendations.	Completion Date: **02/11/2025** Status: **APPROVED** Date: **02/10/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395986	A. BLDG: 00 B. WING:	01/16/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
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P 5530	Continued from page 10 Based on review of nursing time schedules and staff interview it was determined that the facility administrative staff failed to provide a minimum of one licensed practical nurse (LPN) per 25 residents during the day shift on one of 21 days (1/10/25), and one LPN per 30 residents during the evening shift on one of 21 days (1/10/25), and one LPN per 40 residents during the night shift on 13 of 21 days (12/24/24, 12/27/24, 12/28/24, 12/29/24, 12/31/24, 1/1/25, 1/2/25, 1/10/25, 1/11/25, 1/12/25, 1/13/25, 1/14/25, and 1/15/25). Findings include: Review of facility census data and nursing time schedules from 12/22/24 through 12/28/24, 12/29/24 through 1/4/25, and 1/9/25 through 1/15/25 revealed the following LPN staffing shortages. Day Shift: Date Census Full Time Equivalents (FTE) Present FTE Required	P 5530		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395986	A. BLDG: 00 B. WING:	01/16/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
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P 5530	Continued from page 11	P 5530		

1/10/25 97 3.19 3.88

Evening Shift:

Date	Census	FTE Present	FTE Required
1/10/25	97	8.00	8.82

Night Shift:

Date	Census	FTE Present	FTE Required
12/24/24	98	2.13	2.45
12/27/24	99	2.13	2.48
12/28/24	98	2.13	2.45
12/29/24	99	2.38	2.48
12/31/24	98	2.13	2.45
1/1/25	98	2.13	2.45
1/2/25	97	2.13	2.43
1/10/25	97	2.13	2.43
1/11/25	96	2.13	2.40
1/12/25	96	2.13	2.40
1/13/25	95	2.13	2.38
1/14/25	95	2.13	2.38
1/15/25	98	2.13	2.45

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395986	A. BLDG: 00 B. WING:	01/16/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
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P 5530	Continued from page 12 During an interview on 1/16/25, at 3:08 p.m. the Nursing Home Administrator confirmed the staffing shortages and that the facility failed to provide one LPN per 25 residents during the day shift, one LPN per 30 residents during the evening shift, and one LPN per 40 residents on the night shift as required with no additional excess higher-level staff to compensate this deficiency.	P 5530		
P 5640		P 5640		

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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P 5640	Continued from page 13 Nursing services. (2) Effective July 1, 2024, the total number of hours of general nursing care provided in each 24-hour period shall, when totaled for the entire facility, be a minimum of 3.2 hours of direct resident care for each resident. This REGULATION is not met as evidenced by:	P 5640	The facility will continue to maintain the required 3.2 nursing ratios in a 24-hour period and implement a contingency plan if needed by calling in off duty staff, calling sister facilities or utilizing agency as needed to ensure sufficient nursing staff. The RDCS educated NHA/DON/scheduler on ensuring sufficient nursing staff. To monitor and maintain ongoing compliance the NHA/DON/scheduler will complete staffing meetings 2x daily x 5x weekly x4 weeks then 1x daily x5 x weekly ongoing thereafter to ensure sufficient nursing staff. The results of the audits will be forwarded to the facility Quality Assurance Performance Improvement (QAPI) committee for further review and recommendations.	Completion Date: **02/11/2025** Status: **APPROVED** Date: **02/07/2025**

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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P 5640	Continued from page 14 Based on review of nursing time schedules and staff interviews it was determined that the facility administrative staff failed to provide the minimum number of general nursing hours to each resident in a 24 hour period on 11 of 21 days (12/22/24, 12/24/24, 12/25/24, 12/27/24, 12/29/24, 1/4/25, 1/9/25, 1/10/25, 1/11/25, 1/12/25, and 1/14/25). Findings include: Review of facility census data and nursing time schedules from 12/22/24 through 12/28/24, 12/29/24 through 1/4/25, and 1/9/25 through 1/15/25, revealed that the facility failed to maintain 3.20 hours of general nursing care (PPD) to each resident in a 24-hour period on the following dates: Date Census PPD 12/22/24 98 3.03 12/24/24 98 3.17 12/25/24 98 3.16 12/27/24 99 3.06 12/29/24 99 2.97	P 5640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395986	A. BLDG: __00_____ B. WING: _____	01/16/2025

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P 5640	Continued from page 15 1/4/25 96 3.07 1/9/25 97 3.18 1/10/25 97 2.94 1/11/25 96 2.98 1/12/25 96 3.15 1/14/25 95 3.19 During an interview on 1/16/25, at 3:08 p.m. the Nursing Home Administrator confirmed that the facility failed to provide the minimum number of general nursing hours to each resident in a 24-hour period on 11 of 21 days as required.	P 5640		

Certified End Page

KITTANNING HEALTH & REHAB CENTER

STATE LICENSE NUMBER: 234802

SURVEY EXIT DATE: 01/16/2025

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