

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 396093	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/06/2025
NAME OF PROVIDER OR SUPPLIER: RICHFIELD HEALTHCARE AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: PO BOX 248, 631 MAIN STREET RICHFIELD, PA 17086		
STATE LICENSE NUMBER: 260202				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0000	INITIAL COMMENT	F 0000		
F 0568	Based on a Medicare/Medicaid Recertification Survey, State Licensure Survey, Civil Rights Compliance Survey, and an Abbreviated Survey to investigate two Complaints completed on February 6, 2025, it was determined that Richfield Healthcare And Rehabilitation 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 Regulation as they relate to the Health portion of the survey process.	F 0568		
SS=E				

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE:

(X6) DATE:

Any deficiency statement ending with an asterisk (*) denotes a deficiency which may be excused from correction providing it is determined that other safeguards provide sufficient protection to the patients. The findings stated above are disclosable whether or not a plan of correction is provided. The findings are disclosable within 14 days after such information is made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

This form is a printed electronic version of the CMS 2567L. It contains all the information found on the standard document in much the same form. This electronic form once printed and signed by the facility administrator and appropriately posted will satisfy the CMS requirement to post survey information found on the CMS 2567L.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 396093	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/06/2025
NAME OF PROVIDER OR SUPPLIER: RICHFIELD HEALTHCARE AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: PO BOX 248, 631 MAIN STREET RICHFIELD, PA 17086		
STATE LICENSE NUMBER: 260202				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0568 SS=E	Continued from page 1 483.10(f)(10)(iii) Accounting and Records of Personal Funds §483.10(f)(10)(iii) Accounting and Records. (A) The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf. (B) The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident. (C)The individual financial record must be available to the resident through quarterly statements and upon request. This REQUIREMENT is not met as evidenced by:	F 0568	1. Resident 3 and Resident 13, along with their responsible parties, were provided with their personal fund statements immediately upon identification of the issue. 2. The Business Office Manager (BOM) reviewed the personal fund accounts for all residents to ensure no other individuals were missing quarterly statements. Any identified residents were provided with their statements. The facility revised its Personal Funds Management Policy to include a mandatory process for documenting and distributing quarterly statements to residents. 3. The Business Office Manager (BOM) and NHA received re-education on regulatory requirements regarding personal fund statements, including the obligation to provide statements at least quarterly. This training was completed by Seasoned BOM at a sister facility on 2-10-2025. 4.The Business Office Manager or designee will conduct a monthly audit of 5 randomly selected	Completion Date: 03/18/2025 Status: APPROVED Date: 02/18/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 396093	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/06/2025
NAME OF PROVIDER OR SUPPLIER: RICHFIELD HEALTHCARE AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: PO BOX 248, 631 MAIN STREET RICHFIELD, PA 17086		
STATE LICENSE NUMBER: 260202				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0568 SS=E	Continued from page 2	F 0568	residents' personal fund accounts to verify that statements have been provided at least quarterly. Audits will be reviewed in QAPI.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 396093	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/06/2025
NAME OF PROVIDER OR SUPPLIER: RICHFIELD HEALTHCARE AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: PO BOX 248, 631 MAIN STREET RICHFIELD, PA 17086		
STATE LICENSE NUMBER: 260202				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0568 SS=E	Continued from page 3 Based on a review of resident personal fund accounting, clinical record review, and resident, family, and staff interview, it was determined that the facility failed to provide a personal fund quarterly statement for two of two residents reviewed for personal funds concerns (Residents 3 and 13). Findings include: Interview with Resident 3's sister on February 4, 2025, at 11:00 AM indicated that the facility automatically receives Resident 3's social security check monthly. Resident 3's sister stated that she did not know what is done with the personal allowance (now 60 dollars) that Resident 3 is permitted to keep each month. Resident 3's sister stated that she does not receive a statement accounting for Resident 3's money. Interview with Resident 3 on February 4, 2025, at 1:50 PM revealed that Resident 3 could not answer if she had a personal fund, where the accounting statement goes, or how much money she had in the	F 0568		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 396093	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/06/2025
NAME OF PROVIDER OR SUPPLIER: RICHFIELD HEALTHCARE AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: PO BOX 248, 631 MAIN STREET RICHFIELD, PA 17086		
STATE LICENSE NUMBER: 260202				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0568 SS=E	Continued from page 4 account to spend. Review of an accounting statement dated April 1, 2024, to February 13, 2025, revealed that Resident 3 had no debits (withdrawals) from the account with a resulting balance of \$1,772.28. Clinical record review for Resident 13 revealed a, "Resident Fund Management Service," authorization (form the facility utilized to document a resident's desire to establish a resident fund account and have social security payments forwarded directly to the facility) signed by Resident 13 on September 11, 2024. The authorization stipulated that Resident 13 would receive a statement of her account at least quarterly. Interview with Resident 13 and her husband on February 4, 2025, at 12:32 PM revealed that Resident 13's social security payment is forwarded to the facility automatically. The interview confirmed that Resident 13 and her husband understood that Resident 13 is allowed to have an amount monthly	F 0568		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 396093	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/06/2025
NAME OF PROVIDER OR SUPPLIER: RICHFIELD HEALTHCARE AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: PO BOX 248, 631 MAIN STREET RICHFIELD, PA 17086		
STATE LICENSE NUMBER: 260202				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0568 SS=E	Continued from page 5 for a personal allowance and her husband is afforded a spousal support payment each month. Neither Resident 13 nor her husband recalled receiving an accounting statement at least quarterly. Resident 13's husband named Employee 2 (business office manager/human resources director) as the person he would contact for any issues regarding finances. Interview with Employee 2 on February 5, 2025, at 1:26 PM revealed that she did not provide residents with quarterly statements; however, she would have that person speak to the survey team. No facility staff indicated to the survey team that they provided residents their quarterly personal fund statements. Interview with the Nursing Home Administrator on February 5, 2025, at 2:38 PM confirmed that the facility did not have evidence of providing Residents 13 or 3, or their responsible parties, personal fund statements at least quarterly. 28 Pa. Code 201.14(a) Responsibility of licensee	F 0568		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 396093	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/06/2025
NAME OF PROVIDER OR SUPPLIER: RICHFIELD HEALTHCARE AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: PO BOX 248, 631 MAIN STREET RICHFIELD, PA 17086		
STATE LICENSE NUMBER: 260202				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0568 SS=E	Continued from page 6 28 Pa. Code 201.29(a) Resident rights	F 0568		
F 0623 SS=D		F 0623		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 396093	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/06/2025
NAME OF PROVIDER OR SUPPLIER: RICHFIELD HEALTHCARE AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: PO BOX 248, 631 MAIN STREET RICHFIELD, PA 17086		
STATE LICENSE NUMBER: 260202				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0623 SS=D	Continued from page 7 483.15(c)(3)-(6)(8) Notice Requirements Before Transfer/Discharge §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c) (2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)	F 0623	1. The facility can not retroactively correct deficient practice. 2. The facility reviewed any resident transfers from the past 30 days to determine if any other residents or responsible parties were missing written notification of hospital transfers. Any identified deficiencies were immediately corrected. 3. NHA educated Social Services who received re-education on proper hospital transfer notification procedures, including: - The required elements of written notification. - Timely distribution and documentation of notifications. - The resident's right to appeal and required contact information for relevant agencies. - Ensuring responsible parties receive and acknowledge the notification. 4. The NHA and or designee will audit up to 5 random hospital transfers per month for three months to verify that: - Written notifications were	Completion Date: 03/18/2025 Status: APPROVED Date: 02/18/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 396093	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/06/2025	
NAME OF PROVIDER OR SUPPLIER: RICHFIELD HEALTHCARE AND REHABILITATION CENTER STATE LICENSE NUMBER: 260202		STREET ADDRESS, CITY, STATE, ZIP CODE: PO BOX 248, 631 MAIN STREET RICHFIELD, PA 17086		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0623 SS=D	Continued from page 8 (1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i) (A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and	F 0623	completed. - All required elements were included. - Documentation was properly signed and acknowledged by the responsible party and if unable to get signature proof of mailed documentation was provided. Audit results will be reviewed by the QAPI team monthly to determine the need for ongoing monitoring.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 396093	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/06/2025
NAME OF PROVIDER OR SUPPLIER: RICHFIELD HEALTHCARE AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: PO BOX 248, 631 MAIN STREET RICHFIELD, PA 17086		
STATE LICENSE NUMBER: 260202				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0623 SS=D	Continued from page 9 (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(k). This REQUIREMENT is not met as evidenced by:	F 0623		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 396093	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/06/2025	
NAME OF PROVIDER OR SUPPLIER: RICHFIELD HEALTHCARE AND REHABILITATION CENTER STATE LICENSE NUMBER: 260202		STREET ADDRESS, CITY, STATE, ZIP CODE: PO BOX 248, 631 MAIN STREET RICHFIELD, PA 17086		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0623 SS=D	Continued from page 10 Based on clinical record review and staff interview, it was determined that the facility failed to notify a resident and/or their responsible party in writing of a transfer to the hospital with the required information for two of three residents reviewed (Residents 4 and 13). Findings include: Clinical record review for Resident 4 revealed that he was transferred to the hospital from December 3 to 9, 2024, after a change in his condition. There was no documentation that the facility provided written notification to the resident's responsible party regarding the transfer that included the required contents: reason for the transfer, effective date of the transfer, location to which the resident was transferred, a statement of the resident's right to appeal, including the name, contact, email, and address, how to obtain and appeal form, assistance completing and submitting the appeal form and hearing request, contact, email, and address information for the Office of the State Long-Term	F 0623		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 396093	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/06/2025	
NAME OF PROVIDER OR SUPPLIER: RICHFIELD HEALTHCARE AND REHABILITATION CENTER STATE LICENSE NUMBER: 260202		STREET ADDRESS, CITY, STATE, ZIP CODE: PO BOX 248, 631 MAIN STREET RICHFIELD, PA 17086		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0623 SS=D	Continued from page 11 Care Ombudsman, and information for the agency responsible for the protection and advocacy of individuals with developmental disabilities. Interview with Employee 4 (registered nurse supervisor) on February 5, 2025, at 11:49 AM confirmed the above findings for Resident 4. Interview with Resident 13 and her husband on February 4, 2025, at 12:51 PM indicated that she was admitted to the hospital within the past month. Resident 13's husband could not recall if he received a written notice that included the required contents (e.g., reasons for Resident 13's transfer). Resident 13's husband indicated that he is in the facility four days a week on the days that Resident 13 is not out of the facility for hemodialysis (treatment for kidney failure; a machine filters extra fluid and waste products from the blood). Clinical record review for Resident 13 revealed census information that documented Resident 13 began a hospitalization leave of absence on January	F 0623		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 396093	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/06/2025
NAME OF PROVIDER OR SUPPLIER: RICHFIELD HEALTHCARE AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: PO BOX 248, 631 MAIN STREET RICHFIELD, PA 17086		
STATE LICENSE NUMBER: 260202				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0623 SS=D	Continued from page 12 22, 2025. Nursing documentation dated January 29, 2025, at 3:57 PM revealed that Resident 13 returned to the facility from the hospital. A Notice of Transfer or Discharge dated January 23, 2025, indicated that the contracted dialysis provider sent Resident 13 to the hospital due to a low blood pressure and confusion on January 22, 2025. There was no evidence that the facility provided Resident 13's husband this notice. The signature line designated for the resident's or resident's representative's acknowledgement of the notice was blank. The surveyor reviewed the above findings regarding Resident 13 during an interview with the Nursing Home Administrator and the Director of Nursing on February 5, 2025, at 12:31 PM. 28 Pa. Code 201.14 (a) Responsibility of license 28 Pa. Code 201.29(a) Resident rights	F 0623		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 396093	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/06/2025
--	---	---	--

NAME OF PROVIDER OR SUPPLIER: RICHFIELD HEALTHCARE AND REHABILITATION CENTER STATE LICENSE NUMBER: 260202	STREET ADDRESS, CITY, STATE, ZIP CODE: PO BOX 248, 631 MAIN STREET RICHFIELD, PA 17086
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0625 SS=D		F 0625		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 396093	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/06/2025
NAME OF PROVIDER OR SUPPLIER: RICHFIELD HEALTHCARE AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: PO BOX 248, 631 MAIN STREET RICHFIELD, PA 17086		
STATE LICENSE NUMBER: 260202				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0625 SS=D	Continued from page 14 483.15(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	1. Facility can not retroactively correct. 2.The facility conducted a 30-day review of any hospital transfers to determine if any other residents were missing documentation of written bed-hold notifications. Any identified deficiencies were immediately corrected if able. 3. NHA educated Social Services whom received re-education on proper hospital transfer notification. Which include: - The timing of the notice (must be provided at the time of transfer). - Documentation requirements to ensure the notice is placed in the resident's clinical record. - Resident and responsible party acknowledgment procedures. Licensed staff re-educated on the facilities Hospital Transfer Checklist which was re-implemented, requiring the nurse overseeing the transfer to confirm that the bed-hold notice was provided and documented on the Transfer out checklist.	Completion Date: 03/18/2025 Status: APPROVED Date: 02/18/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 396093	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/06/2025
NAME OF PROVIDER OR SUPPLIER: RICHFIELD HEALTHCARE AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: PO BOX 248, 631 MAIN STREET RICHFIELD, PA 17086		
STATE LICENSE NUMBER: 260202				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0625 SS=D	Continued from page 15	F 0625	4. The Director of Nursing (DON) or designee will audit 5 random hospital transfers per month for three months to verify that: - A written bed-hold notice was provided to the resident and/or responsible party. - Documentation was properly signed and checklist was filed in the clinical record. Audit results will be reviewed by the QAPI team monthly to determine the need for ongoing monitoring.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 396093	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/06/2025
NAME OF PROVIDER OR SUPPLIER: RICHFIELD HEALTHCARE AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: PO BOX 248, 631 MAIN STREET RICHFIELD, PA 17086		
STATE LICENSE NUMBER: 260202				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0625 SS=D	Continued from page 16 Based on clinical record review and staff interview, it was determined that the facility failed to provide a written notice of the facility's bed-hold policy to residents or the residents' responsible parties for one of three residents reviewed for hospitalization concerns (Resident 4). Findings include: Clinical record review revealed that Resident 4 was transferred to the hospital from December 3 to 9, 2024, after he had a change in condition. There was no documentation available that the facility provided written notice regarding a bed hold to the resident and the resident's responsible party upon transfer out to the hospital. Interview with Employee 4 (registered nurse supervisor) on February 5, 2025, at 11:49 AM confirmed the above findings for Resident 4. 28 Pa. Code 201.14(a) Responsibility of licensee	F 0625		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 396093	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/06/2025
--	---	---	--

NAME OF PROVIDER OR SUPPLIER: RICHFIELD HEALTHCARE AND REHABILITATION CENTER STATE LICENSE NUMBER: 260202	STREET ADDRESS, CITY, STATE, ZIP CODE: PO BOX 248, 631 MAIN STREET RICHFIELD, PA 17086
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0641 SS=D		F 0641		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 396093	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/06/2025	
NAME OF PROVIDER OR SUPPLIER: RICHFIELD HEALTHCARE AND REHABILITATION CENTER STATE LICENSE NUMBER: 260202		STREET ADDRESS, CITY, STATE, ZIP CODE: PO BOX 248, 631 MAIN STREET RICHFIELD, PA 17086		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0641 SS=D	Continued from page 18 483.20(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	1. The facility immediately corrected Resident 1's MDS and a modification of the MDS's was completed to reflect accurate diagnoses and care needs removing coding that was selected for resident for having an active diagnosis of an infection which included one of the following: pneumonia, septicemia (a bloodstream infection), and a multidrug resistant organism (MDRO, an infection susceptible to certain antibiotics). There was no documented evidence in Resident 1's clinical record to indicate that she had a current pneumonia infection, septicemia, or an MDRO. MDS's were modified and diagnoses were updated to reflect current active diagnoses. 2. MDS staff member conducted a 30 day look back reviewing any residents who were coded for have current pneumonia infection, septicemia, or an MDRO to ensure coding was accurate. - Active diagnoses were verified	Completion Date: 03/18/2025 Status: APPROVED Date: 02/18/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 396093	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/06/2025
NAME OF PROVIDER OR SUPPLIER: RICHFIELD HEALTHCARE AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: PO BOX 248, 631 MAIN STREET RICHFIELD, PA 17086		
STATE LICENSE NUMBER: 260202				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0641 SS=D	Continued from page 19	F 0641	<p>with progress notes, physician orders, and laboratory results with the MDS submission.</p> <ul style="list-style-type: none"> - Any discrepancies will be addressed and modified/updated to reflect current care needs during the look back. <p>3. NHA to educate MDS staff providing re-education on:</p> <ul style="list-style-type: none"> - Proper MDS coding practices, including reviewing physician orders and clinical documentation before finalizing assessments. - The importance of accurate coding to ensure appropriate care planning and reimbursement. <p>4. The MDS Coordinator or designee will audit 5 random selected MDS assessments per month for three months to verify if coding current pneumonia infection, septicemia, or an MDRO to ensure coding was accurate audit will include Active diagnoses accurately reflect the resident's current clinical condition during the MDS assessment look back. Audits will be reviewed in QAPI.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 396093	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/06/2025
NAME OF PROVIDER OR SUPPLIER: RICHFIELD HEALTHCARE AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: PO BOX 248, 631 MAIN STREET RICHFIELD, PA 17086		
STATE LICENSE NUMBER: 260202				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0641 SS=D	Continued from page 20 Based on clinical record review and staff interview, it was determined that the facility failed to ensure complete and accurate Minimum Data Set (MDS) assessments for one of 12 residents reviewed (Resident 1). Findings include: Review of Resident 1's clinical record revealed a nursing note dated December 22, 2023, indicating that the facility readmitted her from a hospital stay where she was diagnosed with aspiration pneumonia (infection in the lungs) and sepsis (a bloodstream infection). A Minimum Data Set Assessment (MDS, a form completed at specific intervals to determine care needs) dated May 30, 2024, indicated the facility assessed her as having pneumonia, septicemia (a bloodstream infection), and a multidrug resistant organism (MDRO, an infection susceptible to certain antibiotics). There was no documented evidence in Resident 1's clinical record to indicate	F 0641		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 396093	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/06/2025
NAME OF PROVIDER OR SUPPLIER: RICHFIELD HEALTHCARE AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: PO BOX 248, 631 MAIN STREET RICHFIELD, PA 17086		
STATE LICENSE NUMBER: 260202				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0641 SS=D	Continued from page 21 that she had a current pneumonia infection, septicemia, or an MDRO. MDS Assessments dated August 1, 2024, August 30, 2024, and November 27, 2024, indicate that the facility continued to assess Resident 1's as having pneumonia, septicemia, and an MDRO. There was no documented evidence in Resident 1's clinical record to indicate that she had a current pneumonia infection, septicemia, or an MDRO since December of 2023. Interview with the Administrator on February 5, 2025, at 12:50 PM confirmed that Resident 1's MDS's dated May 30, 2024, August 1, 2024, August 30, 2024, and November 27, 2024, were coded in error regarding having pneumonia, septicemia, and an MDRO. 28 Pa. Code 211.5(f)(ix) Medical records 28 Pa. Code 211.12(d)(1)(5) Nursing services	F 0641		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 396093	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/06/2025
--	---	---	--

NAME OF PROVIDER OR SUPPLIER: RICHFIELD HEALTHCARE AND REHABILITATION CENTER STATE LICENSE NUMBER: 260202	STREET ADDRESS, CITY, STATE, ZIP CODE: PO BOX 248, 631 MAIN STREET RICHFIELD, PA 17086
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0689 SS=D		F 0689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 396093	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/06/2025	
NAME OF PROVIDER OR SUPPLIER: RICHFIELD HEALTHCARE AND REHABILITATION CENTER STATE LICENSE NUMBER: 260202		STREET ADDRESS, CITY, STATE, ZIP CODE: PO BOX 248, 631 MAIN STREET RICHFIELD, PA 17086		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0689 SS=D	Continued from page 23 483.25(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	1. Resident 5's care plan was updated to include the fall prevention interventions, which include: - Pillow placement behind upper body. - Blanket rolls on both sides of mattress. A full review of Resident 5's fall history was completed by IDT to ensure all interventions are appropriate and accurate to meet the residents needs per plan of care as well to ensure they are in place. 2. DON/IDT will complete a A look back of the past 30 days of residents who had a fall. Falls will be reviewed to ensure interventions are documented in their care plan and are in place to meet the needs of the residents plan of care. Weekly IDT fall meetings will be started to review the falls during that week to ensure appropriate interventions are put in place and documented in their care plan.	Completion Date: 03/18/2025 Status: APPROVED Date: 02/18/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 396093	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/06/2025
NAME OF PROVIDER OR SUPPLIER: RICHFIELD HEALTHCARE AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: PO BOX 248, 631 MAIN STREET RICHFIELD, PA 17086		
STATE LICENSE NUMBER: 260202				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0689 SS=D	Continued from page 24	F 0689	<p>3. DON/designee will provide Re-education for Nursing and IDT Staff on Timely documentation of fall prevention interventions in residents' care plans as well as implementation of weekly fall meetings on reviewing residents who fell and ensuring interventions are appropriate and effective to meet the needs of the resident.</p> <p>4. The DON or designee will audit 5 random resident fall cases per month for three months to ensure:</p> <ul style="list-style-type: none"> - Fall prevention interventions are documented in care plans post fall. - IDT meetings are held within a minimum of 72 hours of each fall. - Weekly IDT Fall meetings are held to discuss residents who fall and to ensure interventions are in place and documented in care plan and meet the plan of care needs. Audit results will be reviewed monthly by the QAPI team to assess trends and determine if ongoing monitoring is necessary. 	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 396093	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/06/2025	
NAME OF PROVIDER OR SUPPLIER: RICHFIELD HEALTHCARE AND REHABILITATION CENTER STATE LICENSE NUMBER: 260202		STREET ADDRESS, CITY, STATE, ZIP CODE: PO BOX 248, 631 MAIN STREET RICHFIELD, PA 17086		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0689 SS=D	Continued from page 25 Based on clinical record review and staff interview, it was determined that the facility failed to implement interventions to prevent future falls or accidents for one of three residents reviewed for falls (Resident 5). Findings include: Clinical record review revealed the facility admitted Resident 5 on November 9, 2017. The facility initiated a care plan noting Resident 5 was at risk for falls on November 27, 2020, due to decreased safety awareness. Nursing documentation dated October 10, 2024, at 5:40 PM noted Resident 5 had an unwitnessed fall. Review of the facility investigation into Resident 5's fall noted he fell out of bed. Resident 5 was found on his right side with his blanket wrapped around him and a 1.8 centimeter (cm) by 0.6 cm abrasion above his ear. The investigation noted no new interventions and indicated staff will discuss at interdisciplinary team meeting (IDT).	F 0689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 396093	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/06/2025
NAME OF PROVIDER OR SUPPLIER: RICHFIELD HEALTHCARE AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: PO BOX 248, 631 MAIN STREET RICHFIELD, PA 17086		
STATE LICENSE NUMBER: 260202				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0689 SS=D	Continued from page 26 Nursing documentation dated October 17, 2024, at 2:35 AM noted Resident 5 was found on floor on the left side of his bed, between his bed and closet. Review of the facility investigation into Resident 5's fall revealed the immediate action the facility took was for staff to place a pillow behind Resident 5's upper body while he was in bed to prevent further falls. Nursing documentation dated December 20, 2024, at 1:59 AM revealed Resident 5 was observed laying on his backside on the floor beside his bed. Documentation noted Resident 5 was assisted back to bed and blanket rolls were placed on bilateral sides of his mattress to remind him of the edges of the mattress. Nursing documentation noted Resident 5's care plan was updated. Further review of Resident 5's care plan revealed the nursing staff never updated his care plan with the intervention of placing a pillow behind Resident 5's upper body while in bed, or the blanket rolls on the	F 0689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 396093	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/06/2025
NAME OF PROVIDER OR SUPPLIER: RICHFIELD HEALTHCARE AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: PO BOX 248, 631 MAIN STREET RICHFIELD, PA 17086		
STATE LICENSE NUMBER: 260202				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0689 SS=D	Continued from page 27 bilateral sides of Resident 5's mattress while in bed. The only documentation the facility was able to provide related to the IDT meeting regarding Resident 5's fall was noted January 8, 2025, after three falls from his bed occurred. Interview with the Director of Nursing on February 6, 2025, at 11:19 AM confirmed the above findings for Resident 5, and was unable to provide any further documentation that Resident 5's care plan was updated to prevent further falls. 28 Pa. Code 211.12(d)(1)(5) Nursing services	F 0689		
F 0756 SS=D		F 0756		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 396093	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/06/2025	
NAME OF PROVIDER OR SUPPLIER: RICHFIELD HEALTHCARE AND REHABILITATION CENTER STATE LICENSE NUMBER: 260202		STREET ADDRESS, CITY, STATE, ZIP CODE: PO BOX 248, 631 MAIN STREET RICHFIELD, PA 17086		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0756 SS=D	Continued from page 28 483.45(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	1. The facility cannot retroactively correct deficient practice. 2. The DON/designee will do a 30 day look back to ensure pharmacy consultant reviews requiring recommendations are reviewed by MD and are followed up on. The facility's Medical Records Coordinator or designee will maintain a log of pharmacist reports, ensuring All residents are listed in each month's review. The attending physician receives and reviews all recommendations. Documentation of physician action is entered into the resident's chart. 3. The NHA will educate Director of Nursing (DON) on: - Verifying that all consultant pharmacist recommendations are received, reviewed, and acted upon by the physician. - Ensuring documentation of physician response is entered into the medical record.	Completion Date: 03/18/2025 Status: APPROVED Date: 02/18/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 396093	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/06/2025
NAME OF PROVIDER OR SUPPLIER: RICHFIELD HEALTHCARE AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: PO BOX 248, 631 MAIN STREET RICHFIELD, PA 17086		
STATE LICENSE NUMBER: 260202				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0756 SS=D	Continued from page 29 §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	4. The DON or designee will audit monthly pharmacy reviews and to ensure recommendations are followed up and completed by a physician and are then placed in the resident records each month. The QAPI team will review pharmacy audits monthly to assess ongoing monitoring.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 396093	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/06/2025	
NAME OF PROVIDER OR SUPPLIER: RICHFIELD HEALTHCARE AND REHABILITATION CENTER STATE LICENSE NUMBER: 260202		STREET ADDRESS, CITY, STATE, ZIP CODE: PO BOX 248, 631 MAIN STREET RICHFIELD, PA 17086		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0756 SS=D	Continued from page 30 Based on clinical record review and staff interview, it was determined that the facility failed to ensure the consultant pharmacist reported irregularities to the attending physician, and that these reports were acted upon, for one of five residents reviewed for medication concerns (Resident 13). Findings include: Consultant pharmacist reports dated July 2, 2024, and October 4, 2024, listed numerous residents who were reviewed during the visits but did not require any recommendations. Resident 13 was not listed in either report. Resident 13's clinical record did not include evidence that a consultant pharmacist reviewed her medication regimen in July 2024, or October 2024. Resident 13's clinical record did not contain a report from the consultant pharmacist for July 2024, or October 2024. Interview with the Nursing Home Administrator and	F 0756		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 396093	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/06/2025
NAME OF PROVIDER OR SUPPLIER: RICHFIELD HEALTHCARE AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: PO BOX 248, 631 MAIN STREET RICHFIELD, PA 17086		
STATE LICENSE NUMBER: 260202				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0756 SS=D	Continued from page 31 the Director of Nursing on February 5, 2025, at 3:16 PM revealed that the facility did not have a report of the consultant pharmacist's recommendations for July 2, 2024, or October 4, 2024. The interview confirmed that since Resident 13's name was not listed among the residents on the available July 2024, or October 2024 reports, she should have had a recommendation forwarded to her physician for those months. The facility failed to ensure that the consultant pharmacist documented on a separate, written report that was sent to the attending physician, and that the physician documented in Resident 13's medical record that the identified irregularity was reviewed, and what, if any, action was taken to address it, for the months of July 2024, and October 2024. 28 Pa. Code 211.9(k) Pharmacy services 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services	F 0756		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 396093	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/06/2025
--	---	---	--

NAME OF PROVIDER OR SUPPLIER: RICHFIELD HEALTHCARE AND REHABILITATION CENTER STATE LICENSE NUMBER: 260202	STREET ADDRESS, CITY, STATE, ZIP CODE: PO BOX 248, 631 MAIN STREET RICHFIELD, PA 17086
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0759 SS=D		F 0759		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 396093	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/06/2025
--	---	---	--

NAME OF PROVIDER OR SUPPLIER: RICHFIELD HEALTHCARE AND REHABILITATION CENTER STATE LICENSE NUMBER: 260202	STREET ADDRESS, CITY, STATE, ZIP CODE: PO BOX 248, 631 MAIN STREET RICHFIELD, PA 17086
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0759 SS=D	Continued from page 33 483.45(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	1. Facility can not retroactively correct deficient practice. Resident 2: - The physician was notified of the insulin administration error, and no adverse effects were noted. - The insulin pen administration policy was reviewed, and staff were re-educated on proper priming procedures. 2. Resident 14: - The physician was notified of the Polyethylene Glycol administration error, and no adverse effects were noted. 2. Facility will review and update their Policy and Procedures specifically - The facility's "Administering Medications" and "Insulin Administration" policies were updated to: - Include detailed priming instructions for all insulin pens based on manufacturer guidelines. - Emphasize measuring	Completion Date: 03/18/2025 Status: APPROVED Date: 02/18/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 396093	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/06/2025	
NAME OF PROVIDER OR SUPPLIER: RICHFIELD HEALTHCARE AND REHABILITATION CENTER STATE LICENSE NUMBER: 260202		STREET ADDRESS, CITY, STATE, ZIP CODE: PO BOX 248, 631 MAIN STREET RICHFIELD, PA 17086		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0759 SS=D	Continued from page 34	F 0759	<p>medications using manufacturer-provided tools.</p> <ul style="list-style-type: none"> - The medication administration policy was reviewed, and staff were re-educated on measuring medications according to manufacturer instructions. <p>3. All licensed nurses will be educated on updated policies and ensuring to follow manufacturer guidelines and will complete competency assessments on:</p> <ul style="list-style-type: none"> - Insulin administration using prefilled pens and priming. - Proper measurement of powdered medications based on manufacturer guidelines. <p>4. The Director of Nursing (DON) or designee will conduct random medication pass audits on five nurses per week for four weeks to ensure:</p> <ul style="list-style-type: none"> - Proper priming of insulin pens. - Correct medication measurement techniques on powdered medications. <p>Audits will be conducted monthly</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 396093	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/06/2025
NAME OF PROVIDER OR SUPPLIER: RICHFIELD HEALTHCARE AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: PO BOX 248, 631 MAIN STREET RICHFIELD, PA 17086		
STATE LICENSE NUMBER: 260202				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0759 SS=D	Continued from page 35	F 0759	for two months and Medication pass audit results will be reviewed in monthly QAPI meetings to ensure continued compliance and determining ongoing auditing.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 396093	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/06/2025
NAME OF PROVIDER OR SUPPLIER: RICHFIELD HEALTHCARE AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: PO BOX 248, 631 MAIN STREET RICHFIELD, PA 17086		
STATE LICENSE NUMBER: 260202				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0759 SS=D	Continued from page 36 Based on a review of select facility policies and procedures, clinical record review, observation, and staff interview, it was determined that the facility failed to ensure a medication error rate below five percent (Residents 2 and 14). Findings include: The facility's medication error rate was eight percent based on 25 medication opportunities with two medication errors. The facility policy entitled, "Administering Medications," last reviewed without changes on December 31, 2024, indicated that medications are administered in accordance with prescriber orders. Each nurses' station has a current Physician's Desk Reference (PDR) and/or other medication reference, as well as a copy of the surveyor guidance for pharmacy services available. Manufacturer's instructions or users' manuals related to any medication administration devices are kept with the devices or at the nurses' station.	F 0759		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 396093	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/06/2025	
NAME OF PROVIDER OR SUPPLIER: RICHFIELD HEALTHCARE AND REHABILITATION CENTER STATE LICENSE NUMBER: 260202		STREET ADDRESS, CITY, STATE, ZIP CODE: PO BOX 248, 631 MAIN STREET RICHFIELD, PA 17086		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0759 SS=D	Continued from page 37 The facility policy entitled, "Insulin Administration," last reviewed without changes on December 31, 2024, revealed the nursing staff would have access to specific instructions (from the manufacturer if appropriate) on all forms of insulin delivery systems prior to their use. There was no reference to the administration of insulin via single-patient-use prefilled pens that would include the appropriate technique for priming the disposable needle before use. Clinical record review for Resident 2 revealed an active physician's order for staff to administer two units of Insulin Aspart with Niacinamide (Fiasp FlexTouch, a disposable single-patient-use prefilled pen containing insulin, an injectable hormone used to lower blood sugar) before meals when the blood glucose assessment (small sample of blood obtained via a finger prick is placed on a test strip and read by a glucose meter device) is within the range of 151 to 200 mg/dL (milligrams per deciliter).	F 0759		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 396093	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/06/2025
NAME OF PROVIDER OR SUPPLIER: RICHFIELD HEALTHCARE AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: PO BOX 248, 631 MAIN STREET RICHFIELD, PA 17086		
STATE LICENSE NUMBER: 260202				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0759 SS=D	Continued from page 38 Manufacturer's instructions for the Fiasp FlexTouch pen stipulate that the user is to prime the pen before each injection. After application of a disposable needle, step seven of the instructions notes to turn the dose selector to select two units. Step eight instructs to hold the pen with the needle pointing up and tap the top of the pen gently a few times to let any air bubbles rise to the top. Step nine instructs to hold the pen with the needle pointing up and press and hold in the dose button until the dose counter shows zero. Step ten, dose selection, instructs to check to make sure the dose selector is set at zero and turn the dose selector to select the number of units you need to inject. Observation of a medication administration pass on February 4, 2025, at 11:57 AM revealed Employee 1 (licensed practical nurse, LPN) prepared medications for administration for Resident 2. Employee 1 obtained a blood glucose assessment of 199 mg/dL. Employee 1 obtained a Fiasp Flextouch insulin pen and a disposable needle from the medication cart. Employee 1 applied the needle	F 0759		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 396093	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/06/2025
NAME OF PROVIDER OR SUPPLIER: RICHFIELD HEALTHCARE AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: PO BOX 248, 631 MAIN STREET RICHFIELD, PA 17086		
STATE LICENSE NUMBER: 260202				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0759 SS=D	Continued from page 39 to the tip of the Fiasp Flextouch pen and dialed one unit to prime the needle (returning the reading on the window of the pen to zero). Employee 1, then, dialed two units for administration to Resident 2. Employee 1 did not prime the needle with two units of insulin before preparing the physician ordered dose of two units. Employee 1 entered Resident 2's room and administered the insulin medication into Resident 2's right upper arm. Clinical record review for Resident 14 revealed an active physician's order for staff to administer Polyethylene Glycol (laxative to stimulate bowel movements), 3350 oral powder, 17 grams per scoop; give one scoop by mouth in the afternoon for constipation, mix in four to eight ounces of fluid. Instructions on the Polyethylene Glycol container inform the user to use the cap of the container, fill powder to the top of the cap, to obtain a dose of 17 grams. Continued observation of the medication	F 0759		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 396093	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/06/2025
NAME OF PROVIDER OR SUPPLIER: RICHFIELD HEALTHCARE AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: PO BOX 248, 631 MAIN STREET RICHFIELD, PA 17086		
STATE LICENSE NUMBER: 260202				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0759 SS=D	Continued from page 40 administration pass on February 4, 2025, at 1:10 PM, revealed Employee 1 prepared Polyethylene Glycol for Resident 14. Employee 1 used a plastic medication cup to determine how much of the medication powder to administer. Employee 1 stated that her goal was to fill the medication cup to just over 15 milliliters. Employee 1 did not use the cap of the Polyethylene Glycol container to measure the dose. Employee 1 mixed the powder in water, entered Resident 14's room, and administered the medication to Resident 14. Interview with Employee 1 on February 4, 2025, at 2:25 PM confirmed that she primed Resident 2's insulin needle with only one unit of insulin. Employee 1 did not have a Fiasp FlexTouch pen package insert or the manufacturer's instructions to know that the proper priming technique required two units. Observation of Resident 14's Polyethylene Glycol container instructions with Employee 1 confirmed that the user is to use the container cap to measure 17 grams of the medication. Employee 1 verified that if she used the	F 0759		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 396093	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/06/2025
NAME OF PROVIDER OR SUPPLIER: RICHFIELD HEALTHCARE AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: PO BOX 248, 631 MAIN STREET RICHFIELD, PA 17086		
STATE LICENSE NUMBER: 260202				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0759 SS=D	Continued from page 41 medication container cap versus a plastic medication cup, Resident 14 would have received more of the medication powder. The surveyor reviewed the concerns regarding the above medication pass observations during an interview with the Nursing Home Administrator and the Director of Nursing on February 5, 2025, at 12:31 PM. 28 Pa. Code 211.9(a)(1) Pharmacy services 28 Pa. Code 211.10(a)(c) Resident care policies 28 Pa. Code 211.12(d)(1)(5) Nursing services	F 0759		
F 0761 SS=D		F 0761		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 396093	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/06/2025
--	---	---	--

NAME OF PROVIDER OR SUPPLIER: RICHFIELD HEALTHCARE AND REHABILITATION CENTER STATE LICENSE NUMBER: 260202	STREET ADDRESS, CITY, STATE, ZIP CODE: PO BOX 248, 631 MAIN STREET RICHFIELD, PA 17086
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0761 SS=D	<p>Continued from page 42</p> <p>483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals</p> <p>§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.</p> <p>§483.45(h) Storage of Drugs and Biologicals</p> <p>§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.</p> <p>§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.</p> <p>This REQUIREMENT is not met as evidenced by:</p>	F 0761	<p>1. Resident 14 The physician was immediately notified of the medication label discrepancy. No medication error occurred as the labeled only had discrepancy nurses followed order in EHR system. The pharmacy was contacted, and a corrected label was issued to match the active physician's order.</p> <p>2. Full house medication cart audit will be completed to ensure labels are cross-checked against physician orders. - If discrepancies are identified, the pharmacy and physician will be notified immediately for resolution if it is the same medication dosage but change in time a change in direction label will be placed on medication until new medication with updated labeled matching the order is received from the pharmacy.</p> <p>3. DON will provide Re-education to licensed Nursing Staff on proper medication verification procedures, emphasizing the importance of ensuring that:</p>	<p>Completion Date: 03/18/2025 Status: APPROVED Date: 02/18/2025</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 396093	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/06/2025
NAME OF PROVIDER OR SUPPLIER: RICHFIELD HEALTHCARE AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: PO BOX 248, 631 MAIN STREET RICHFIELD, PA 17086		
STATE LICENSE NUMBER: 260202				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0761 SS=D	Continued from page 43	F 0761	<ul style="list-style-type: none"> - The medication label matches the active physician's order. - Any discrepancies are immediately reported to the pharmacy and physician before administration. <p>4. The Director of Nursing (DON) or designee will conduct random weekly audits of medication labels vs. physician orders for four weeks to ensure compliance than monthly x 2 months. Medication label audit results will be reviewed in monthly QAPI to determine ongoing monitoring.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 396093	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/06/2025
NAME OF PROVIDER OR SUPPLIER: RICHFIELD HEALTHCARE AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: PO BOX 248, 631 MAIN STREET RICHFIELD, PA 17086		
STATE LICENSE NUMBER: 260202				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0761 SS=D	Continued from page 44 Based on a review of select facility policies and procedures, clinical record review, observation, and staff interview, it was determined that the facility failed to ensure medication was labeled in accordance with accepted professional standards for one of 16 residents reviewed for medication administration (Resident 14). Findings include: The facility policy entitled, "Administering Medications," last reviewed without changes on December 31, 2024, indicated that medications are administered in accordance with prescriber orders. The individual administering the medication checks the label three times to verify the right resident, right medication, right dosage, right time, and right method (route) of administration before giving the medication. Clinical record review for Resident 14 revealed an active physician's order for staff to administer Clonazepam (used to control and prevent seizures)	F 0761		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 396093	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/06/2025	
NAME OF PROVIDER OR SUPPLIER: RICHFIELD HEALTHCARE AND REHABILITATION CENTER STATE LICENSE NUMBER: 260202		STREET ADDRESS, CITY, STATE, ZIP CODE: PO BOX 248, 631 MAIN STREET RICHFIELD, PA 17086		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0761 SS=D	Continued from page 45 oral disintegrating tablet 0.5 milligrams (mg), one tablet by mouth two times a day and two tablets by mouth in the afternoon. Observation of the medication administration pass on February 4, 2025, at 1:10 PM revealed Employee 1 (licensed practical nurse) prepared the Clonazepam 0.5 mg medication for Resident 14. Employee 1 poured two tablets of the Clonazepam medication for administration. The label on the medication instructed staff to administer one tablet by mouth twice daily; and two tablets by mouth at bedtime. Interview with Employee 1 on February 4, 2025, at 2:25 PM confirmed that the Clonazepam label instructed staff to administer one tablet twice a day and two tablets at bedtime; however, that did not agree with the active physician's order for Resident 14. Employee 1 confirmed that the label indicated that the pharmacy filled 30 tablets of this medication on January 24, 2025, and there were 23 tablets available on the date and time of the observation	F 0761		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 396093	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/06/2025
NAME OF PROVIDER OR SUPPLIER: RICHFIELD HEALTHCARE AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: PO BOX 248, 631 MAIN STREET RICHFIELD, PA 17086		
STATE LICENSE NUMBER: 260202				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0761 SS=D	Continued from page 46 (seven tablets had been administered from this medication supply before Employee 1 removed two additional tablets). The surveyor reviewed the concerns regarding the above medication labeling during an interview with the Nursing Home Administrator and the Director of Nursing on February 5, 2025, at 12:31 PM. 28 Pa. Code 211.9(a)(1) Pharmacy services 28 Pa. Code 211.10(a)(c) Resident care policies 28 Pa. Code 211.12(d)(1)(5) Nursing services	F 0761		
F 0791 SS=D		F 0791		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 396093	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/06/2025	
NAME OF PROVIDER OR SUPPLIER: RICHFIELD HEALTHCARE AND REHABILITATION CENTER STATE LICENSE NUMBER: 260202		STREET ADDRESS, CITY, STATE, ZIP CODE: PO BOX 248, 631 MAIN STREET RICHFIELD, PA 17086		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0791 SS=D	Continued from page 47 483.55(b)(1)-(5) Routine/Emergency Dental Srvcs in NFs §483.55 Dental Services The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(b) Nursing Facilities. The facility- §483.55(b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(f) of this part, the following dental services to meet the needs of each resident: (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services; §483.55(b)(2) Must, if necessary or if requested, assist the resident- (i) In making appointments; and (ii) By arranging for transportation to and from the dental services locations; §483.55(b)(3) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay;	F 0791	1. Resident 4: - The dentist was contacted for an evaluation of Resident 4's dental needs. The resident's dental care plan was updated to ensure routine six-month dental cleanings and ongoing monitoring for additional care needs. Resident 3: - A dental appointment was scheduled to reassess the condition of Resident 3's teeth and determine the need for extractions. Resident 3 was placed on a recurring schedule for prophylactic cleanings every six months, per State Plan coverage. 2. The Social Services Director (or designee) will conduct monthly audits to ensure all residents are receiving routine dental services and timely interventions for identified dental needs. The Facility will implement a designated staff member who will have and maintain a standardized process for tracking and following up on dentist recommendations with a Dental	Completion Date: 03/18/2025 Status: APPROVED Date: 02/18/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 396093	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/06/2025
NAME OF PROVIDER OR SUPPLIER: RICHFIELD HEALTHCARE AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: PO BOX 248, 631 MAIN STREET RICHFIELD, PA 17086		
STATE LICENSE NUMBER: 260202				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0791 SS=D	Continued from page 48 §483.55(b)(4) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; and §483.55(b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan. This REQUIREMENT is not met as evidenced by:	F 0791	Services Log to track all resident dental visits, cleanings, and follow-ups. 3. The NHA will provide education to the DON and social service staff as well as a designated designee assigned to this with re-educated on routine and as-needed dental care, including: - Proper documentation of dental services provided. - Scheduling requirements for semi-annual cleanings and dentist referrals for issues such as broken teeth or cavities. - Timely follow-up on dentist recommendations and care plan updates. - calendar record maintained for compliance tracking. 4. The DON or designee will conduct random chart audits weekly for four weeks to ensure all residents are receiving appropriate dental services and care. Audit results will be reviewed in QAPI meetings to determine ongoing monitoring.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 396093	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/06/2025
NAME OF PROVIDER OR SUPPLIER: RICHFIELD HEALTHCARE AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: PO BOX 248, 631 MAIN STREET RICHFIELD, PA 17086		
STATE LICENSE NUMBER: 260202				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0791 SS=D	Continued from page 49 Based on clinical record review, observation, and staff interview, it was determined that the facility failed to assist residents to obtain routine dental care for two of two residents reviewed (Residents 4 and 3). Findings include: Observation of Resident 4 on February 4, 2025, at 11:42 AM revealed he had several broken and missing teeth. Resident 4 was unable to be interviewed due to his cognitive status. Clinical record review revealed the facility admitted him on February 23, 2024. Review of Resident 4's admission MDS (Minimum Data Set, an assessment completed at specific intervals to determine care needs) dated February 29, 2024, revealed staff assessed Resident 4 as having no obvious or likely cavity or broken natural teeth. Further review of Resident 4's clinical record revealed nursing documentation dated January 26,	F 0791		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 396093	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/06/2025	
NAME OF PROVIDER OR SUPPLIER: RICHFIELD HEALTHCARE AND REHABILITATION CENTER STATE LICENSE NUMBER: 260202		STREET ADDRESS, CITY, STATE, ZIP CODE: PO BOX 248, 631 MAIN STREET RICHFIELD, PA 17086		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0791 SS=D	Continued from page 50 2025, at 1:54 PM noting Resident 4 reports that he broke a tooth today in the right upper front of his mouth. A tooth was noted to be broken in the front side of Resident 4's mouth. Nursing documentation dated January 27, 2025, at 7:15 AM revealed the Director of Nursing assessed Resident 4's mouth due to the broken tooth. The Director of Nursing noted Resident 4's teeth were obviously decayed. Nursing documentation dated January 30, 2025, at 9:47 PM revealed the registered nurse spoke to Resident 4's wife about his broken tooth. Resident 4's wife stated it was in Resident 4's upper left side of his mouth. His wife stated he does have a tooth on the right side that is broken off, but his wife stated that "wasn't new." Further review of Resident 4's clinical record revealed he saw the dentist for a comprehensive assessment on October 7, 2024. There was no documentation that Resident 4 received any	F 0791		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 396093	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/06/2025
NAME OF PROVIDER OR SUPPLIER: RICHFIELD HEALTHCARE AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: PO BOX 248, 631 MAIN STREET RICHFIELD, PA 17086		
STATE LICENSE NUMBER: 260202				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0791 SS=D	Continued from page 51 prophylactic cleanings of his teeth by a dental hygienist since admission. The facility provided no evidence that Resident 4 received routine prophylactic dental cleanings in the past year as covered under the State plan. Interview with the Director of Nursing on February 6, 2025, at 12:45 PM confirmed these findings. Observation of Resident 3 on February 4, 2025, at 1:51 PM revealed that she had discolored, possibly broken, and missing teeth. Interview with Resident 3 on the date and time of the observation revealed that she believed that she had a tooth that needed pulled (extracted). Clinical record review for Resident 3 revealed progress note documentation by the facility's consultant dentist dated July 29, 2024, that indicated Resident 3 had two non-restorable teeth that was recommended for extraction as needed, and Resident 3 had partial dentition.	F 0791		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 396093	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/06/2025
NAME OF PROVIDER OR SUPPLIER: RICHFIELD HEALTHCARE AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: PO BOX 248, 631 MAIN STREET RICHFIELD, PA 17086		
STATE LICENSE NUMBER: 260202				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0791 SS=D	Continued from page 52 Progress note documentation by the facility's consultant dental hygienist dated September 4, 2024, indicated that Resident 3 received adult prophylaxis (professional dental cleaning). An annual MDS dated February 7, 2024, identified that Resident 3 had obvious, or likely, cavities or broken natural teeth, and the assessment triggered the need for a care plan. A plan of care initiated by the facility on March 24, 2020, to address Resident 3's dental or oral cavity health problem related to possible carious/broken teeth listed interventions that included refer to the dentist/hygienist annually and as needed. Resident 3's clinical record did not provide evidence that the facility provided routine dental services to the extent covered under the State plan (e.g., every six months). The surveyor reviewed the above findings regarding	F 0791		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 396093	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/06/2025
NAME OF PROVIDER OR SUPPLIER: RICHFIELD HEALTHCARE AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: PO BOX 248, 631 MAIN STREET RICHFIELD, PA 17086		
STATE LICENSE NUMBER: 260202				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0791 SS=D	Continued from page 53 Resident 3 with the Director of Nursing on February 5, 2025, at 2:15 PM. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services	F 0791		
F 0812 SS=E		F 0812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 396093	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/06/2025
NAME OF PROVIDER OR SUPPLIER: RICHFIELD HEALTHCARE AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: PO BOX 248, 631 MAIN STREET RICHFIELD, PA 17086		
STATE LICENSE NUMBER: 260202				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0812 SS=E	Continued from page 54 483.60(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	1. Facility cannot retroactively correct. Expired and Improperly Labeled Food Items: - All expired food items (orange juice, applesauce, mixed fruit, and pickle relish) were immediately discarded. Improper Storage of Scooping Utensils: - Sugar and thickener bins were discarded and replaced with properly stored products 2. Expired and Improperly Labeled Food Items: Kitchen staff re-educated on the facility's Food Storage Guidelines, including proper labeling with "use by" dates and discard dates for perishable items. Daily checks for expired food implemented, with findings logged and reviewed by the Dietary Manager. Improper Storage of Scooping Utensils: Dietary Staff re-trained on proper	Completion Date: 03/18/2025 Status: APPROVED Date: 02/18/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 396093	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/06/2025	
NAME OF PROVIDER OR SUPPLIER: RICHFIELD HEALTHCARE AND REHABILITATION CENTER STATE LICENSE NUMBER: 260202		STREET ADDRESS, CITY, STATE, ZIP CODE: PO BOX 248, 631 MAIN STREET RICHFIELD, PA 17086		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0812 SS=E	Continued from page 55	F 0812	<p>storage of scooping utensils, ensuring all utensils are stored outside food containers in designated, covered storage areas.</p> <p>3. Dietary manager will educate dietary staff on: <ul style="list-style-type: none"> - Proper food storage and labeling policies. - Shelf life and expiration date tracking for all perishable and non-perishable items. - Proper handling and storage of food scoops and utensils. </p> <p>4. Dietary manager and or designee will conduct Daily kitchen audits to verify compliance with food storage policies. The Dietary Manager and or designee will conduct weekly food inventory checks, ensuring: <ul style="list-style-type: none"> - All food items are properly labeled and stored. - No expired products remain in storage. <p>Audits will be completed weekly for four weeks than monthly x 2 months. Results of audits will be reviewed in QAPI to determine ongoing monitoring.</p> </p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 396093	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/06/2025
NAME OF PROVIDER OR SUPPLIER: RICHFIELD HEALTHCARE AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: PO BOX 248, 631 MAIN STREET RICHFIELD, PA 17086		
STATE LICENSE NUMBER: 260202				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0812 SS=E	Continued from page 56 Based on review of facility policies and procedures, observation, and staff interview, it was determined that the facility failed to store food in a manner to prevent potential food borne illness in the facility's main kitchen. Findings include: The facility policy entitled, "Food Storage," last reviewed without changes on December 31, 2024, revealed that scoops must be provided for flour, sugar, cereals, dried vegetables, and spices. Scoops are not to be stored in the food containers but are kept covered in a protected area near the containers. The "Guidelines for Storage," instructed staff to, "Date your products with Use by Dates." Observation of the facility's kitchen on February 4, 2025, at 9:50 AM with Employee 3, dietary manager, revealed the following observations: A reach-in refrigerator with the following items: A 46-ounce carton of orange juice labeled as	F 0812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 396093	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/06/2025
NAME OF PROVIDER OR SUPPLIER: RICHFIELD HEALTHCARE AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: PO BOX 248, 631 MAIN STREET RICHFIELD, PA 17086		
STATE LICENSE NUMBER: 260202				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0812 SS=E	Continued from page 57 opened on January 4, 2025, and a use by date of January 11, 2025. A portioned serving of applesauce labeled with a use by date of February 1, 2025 A portioned serving of mixed fruit with a use by date of February 2, 2025 A shelf below a food preparation table contained a 25-pound bin with a white substance identified by Employee 3 as sugar. The scooping utensil used by staff to obtain the food item was stored within the bin in contact with the food product. Interview with Employee 3 on February 4, 2025, at 9:54 AM confirmed that staff are not to store the scooping utensils with food products after use. A food preparation area stored a 20-pound bin of a white substance labeled, "thickener." The scoop used by staff to obtain the food product was stored inside the bin in contact with the food product. Observation of a reach-in refrigerator on February	F 0812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 396093	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/06/2025
NAME OF PROVIDER OR SUPPLIER: RICHFIELD HEALTHCARE AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: PO BOX 248, 631 MAIN STREET RICHFIELD, PA 17086		
STATE LICENSE NUMBER: 260202				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0812 SS=E	Continued from page 58 4, 2025, at 10:00 AM revealed a one-gallon container of pickle relish dated December 15, 2024. Interview with Employee 3 at the time of the observation revealed that the date would indicate staff opened the container on that date, and that the item did not have a use by date indicated; however, the item should have been discarded in one month. Kitchen staff referred to the Guidelines for Storage document, which indicated that pickles stored in the refrigerator were good for one month. The surveyor reviewed the above facility kitchen concerns during an interview with the Nursing Home Administrator and the Director of Nursing on February 5, 2025, at 11:00 AM. 483.60(i) Food safety requirements Previously cited 3/1/24 28 Pa. Code 201.14 (a) Responsibility of Licensee	F 0812		
F 0880 SS=E		F 0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 396093	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/06/2025	
NAME OF PROVIDER OR SUPPLIER: RICHFIELD HEALTHCARE AND REHABILITATION CENTER STATE LICENSE NUMBER: 260202		STREET ADDRESS, CITY, STATE, ZIP CODE: PO BOX 248, 631 MAIN STREET RICHFIELD, PA 17086		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0880 SS=E	Continued from page 59 483.80(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. Facility cannot retroactively correct. Employee 1 was immediately re-educated on proper handwashing technique, emphasizing the requirement to use a disposable towel to turn off faucets. 2. The Handwashing Policy was reviewed and reaffirmed with all staff. Copies of the policy and step-by-step handwashing guides are now posted at all handwashing stations. 3. Hand Hygiene Competency Checks and re-education on handwashing policy to be completed. - All licensed nurses and CNAs will undergo a hand hygiene skills check-off by the Infection Preventionist or Director of Nursing (DON) and or designee to ensure compliance following the education on the facilities handwashing policy. 4. The DON, Infection Preventionist, or designee will conduct weekly	Completion Date: 03/18/2025 Status: APPROVED Date: 02/18/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 396093	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/06/2025
NAME OF PROVIDER OR SUPPLIER: RICHFIELD HEALTHCARE AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: PO BOX 248, 631 MAIN STREET RICHFIELD, PA 17086		
STATE LICENSE NUMBER: 260202				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0880 SS=E	Continued from page 60 (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	random hand hygiene competencies for 4 weeks than monthly x 2 months. Audit findings will be documented and reviewed in monthly Quality Assurance & Performance Improvement (QAPI) meetings.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 396093	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/06/2025
--	---	---	--

NAME OF PROVIDER OR SUPPLIER: RICHFIELD HEALTHCARE AND REHABILITATION CENTER STATE LICENSE NUMBER: 260202	STREET ADDRESS, CITY, STATE, ZIP CODE: PO BOX 248, 631 MAIN STREET RICHFIELD, PA 17086
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0880 SS=E	Continued from page 61	F 0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 396093	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/06/2025	
NAME OF PROVIDER OR SUPPLIER: RICHFIELD HEALTHCARE AND REHABILITATION CENTER STATE LICENSE NUMBER: 260202	STREET ADDRESS, CITY, STATE, ZIP CODE: PO BOX 248, 631 MAIN STREET RICHFIELD, PA 17086			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0880 SS=E	Continued from page 62 Based on a review of select facility policies and procedures, observation, and staff interview, it was determined that the facility failed to ensure an environment free from the potential spread of infection on one of two nursing units (first floor; Residents 13, 18, 2, 14, 20, and 16). Findings include: The facility policy entitled, "Handwashing Policy," last reviewed without changes on December 31, 2024, indicated that the purpose of the policy was to reduce the risk of infection and ensure a safe and hygienic environment throughout the facility. Staff are to use a disposable towel to turn off the faucet as the last step of the handwashing technique. Observation of a medication administration pass on February 4, 2025, at 11:35 AM revealed Employee 1 (licensed practical nurse, LPN) administered medications to Resident 13. Employee 1 washed her hands at a sink in Resident 13's room but used the back of her arm to turn off the faucet.	F 0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 396093	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/06/2025
NAME OF PROVIDER OR SUPPLIER: RICHFIELD HEALTHCARE AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: PO BOX 248, 631 MAIN STREET RICHFIELD, PA 17086		
STATE LICENSE NUMBER: 260202				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0880 SS=E	Continued from page 63 Continued observation of the medication administration pass on February 4, 2025, at 11:44 AM revealed Employee 1 began to prepare medications for administration to Resident 18. Employee 1 stated that she was going to choose to wear a mask, gown, and gloves to enter Resident 18's room because he was experiencing symptoms of potential gastrointestinal infection. After administering Resident 18's medications, Employee 1 removed her mask, gown, and gloves, and washed her hands at a sink in the hallway. Employee 1 used the back of her arm to turn off the faucet after washing her hands. Continued observation of the medication administration pass for Resident 2 on February 4, 2025, at 11:57 AM revealed that Employee 1 donned gloves to obtain a blood glucose assessment (small sample of blood obtained via a finger prick is placed on a test strip and read by a glucose meter device). Employee 1 removed her gloves and washed her hands at a sink in the hallway.	F 0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 396093	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/06/2025
NAME OF PROVIDER OR SUPPLIER: RICHFIELD HEALTHCARE AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: PO BOX 248, 631 MAIN STREET RICHFIELD, PA 17086		
STATE LICENSE NUMBER: 260202				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0880 SS=E	Continued from page 64 Employee 1 used the back of her arm to turn off the faucet after washing her hands. Employee 1 prepared Resident 2's medications, donned gloves, and administered an insulin (injectable hormone used to lower blood sugar) injection into Resident 2's right arm. Employee 1 removed her gloves and washed her hands at a sink in the hallway. Employee 1 used the back of her arm to turn off the faucet after washing her hands. Observation of the medication administration pass on February 4, 2025, at 1:17 PM revealed Employee 1 administered medications to Resident 14. Employee 1 washed her hands in Resident 14's room sink but used the back of her arm to turn off the faucet. Observation of a medication administration pass on February 4, 2025, at 1:31 PM revealed Employee 1 administered medications to Resident 20. Employee 1 washed her hands at a sink in Resident 20's room but used the back of her arm to turn off the faucet.	F 0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 396093	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/06/2025
NAME OF PROVIDER OR SUPPLIER: RICHFIELD HEALTHCARE AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: PO BOX 248, 631 MAIN STREET RICHFIELD, PA 17086		
STATE LICENSE NUMBER: 260202				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0880 SS=E	Continued from page 65 Observation of a medication administration pass on February 4, 2025, at 1:39 PM revealed Employee 1 administered medications to Resident 16. Employee 1 washed her hands at a sink in Resident 16's room but used the back of her arm to turn off the faucet. Interview with Employee 1 on February 4, 2025, at 2:25 PM confirmed that she did not use a disposable towel to turn off the faucet after washing her hands multiple times during the medication administration passes. The surveyor reviewed the concerns regarding handwashing observations during an interview with the Nursing Home Administrator and the Director of Nursing on February 5, 2025, at 12:31 PM. 28 Pa. Code 211.10(a)(c) Resident care policies 28 Pa. Code 211.12(d)(1)(5) Nursing services	F 0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 396093	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/06/2025
NAME OF PROVIDER OR SUPPLIER: RICHFIELD HEALTHCARE AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: PO BOX 248, 631 MAIN STREET RICHFIELD, PA 17086		
STATE LICENSE NUMBER: 260202				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
P 5540	Nursing services. (5) Effective July 1, 2023, a minimum of 1 RN per 250 residents during all shifts. This REGULATION is not met as evidenced by:	P 5540	<p>1. Facility can not retroactively correct.</p> <p>2. Facility can not retroactively correct, Facility will continue to recruit and retain RN staff through a variety of services.</p> <p>3.NHA/Designee will educate the scheduler and DON on state regulation.</p> <p>DON or designee will conduct review of staffing deployment assignments daily to ensure the staffing ratio is being met for a period of 4 weeks and a weekly review x 2 months. Results of the audit will be presented for review and recommendations at the monthly QAPI meeting.</p>	<p>Completion Date: 03/18/2025</p> <p>Status: APPROVED</p> <p>Date: 02/18/2025</p>
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE:		(X6) DATE:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 396093	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/06/2025	
NAME OF PROVIDER OR SUPPLIER: RICHFIELD HEALTHCARE AND REHABILITATION CENTER STATE LICENSE NUMBER: 260202		STREET ADDRESS, CITY, STATE, ZIP CODE: PO BOX 248, 631 MAIN STREET RICHFIELD, PA 17086		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
P 5540	<p>Continued from page 1</p> <p>Based on a review of nursing staffing hours and staff interviews, it was determined that the facility failed to ensure a minimum of one registered nurse (RN) per 250 residents on the overnight shift on eight of the 21 days reviewed.</p> <p>Findings include:</p> <p>A review of nursing care hours provided by the facility dated from November 25 through December 1, 2024, December 23 through December 29, 2024, and January 30, through February 5, 2025, revealed the following:</p> <p>Overnight shift (requires one RN per 250 residents):</p> <p>November 25, 2024, census of 36 with 0.75 RNs, required 1.00 November 29, 2024, census of 37 with 0.50 RNs, required 1.00 November 30, 2024, census of 36 with 0.50 RNs, required 1.00 December 1, 2024, census of 36 with 0.50 RNs,</p>	P 5540		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 396093	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/06/2025	
NAME OF PROVIDER OR SUPPLIER: RICHFIELD HEALTHCARE AND REHABILITATION CENTER STATE LICENSE NUMBER: 260202		STREET ADDRESS, CITY, STATE, ZIP CODE: PO BOX 248, 631 MAIN STREET RICHFIELD, PA 17086		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
P 5540	Continued from page 2 required 1.00 December 25, 2024, census of 31 with no RN, required 1.00 December 27, 2024, census of 33 with no RN, required 1.00 February 2, 2025, census of 30 with no RN, required 1.00 February 5, 2025, census of 35 with 0.63 RNs, required 1.00 Interview with the Nursing Home Administrator and the Director of Nursing on February 6, 2025, at 12:47 PM confirmed that the facility did not meet regulatory registered nurse-to-resident ratios as evidenced above.	P 5540		



Certified End Page

RICHFIELD HEALTHCARE AND REHABILITATION CENTER

STATE LICENSE NUMBER: 260202

SURVEY EXIT DATE: 02/06/2025

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