

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 396116	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/16/2025
NAME OF PROVIDER OR SUPPLIER: LITTLE SISTERS OF THE POOR		STREET ADDRESS, CITY, STATE, ZIP CODE: 1028 BENTON AVENUE PITTSBURGH, PA 15212		
STATE LICENSE NUMBER: 340302				
(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 0684	Based on an Abbreviated Survey in response to an incident, completed on April 16, 2025, it was determined that Little Sister Of The Poor was not in compliance with the following requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities and the 28 Pa. Code, Commonwealth of Pennsylvania Long Term Care Licensure Regulations.	F 0684		
SS=D				

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

TITLE:

(X6) DATE:

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

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

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F 0684 SS=D	Continued from page 1 483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by:	F 0684	1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? - Resident R1 now has a Wander Guard and was moved to the first floor where the Wander Guard alarms are located. Resident R1 was assessed for injury and family was notified on 4/16/2025. The physician was notified of the elopement on 4/05/2025 at 16:30. 2. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? - On 5/01/2025 an audit was completed on the nursing notes for all residents over the past 30 days. Only Resident R1 is exit-seeking and verbalizing desire to leave. This occurs almost every day. On the night shift there will always be a staff person to monitor her whereabouts. - All nursing staff were educated on the facility policy including	Completion Date: 05/16/2025 Status: APPROVED Date: 05/05/2025

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F 0684 SS=D	Continued from page 2	F 0684	<p>physician notification with elopement events on 4/15/2025 and 4/16/2025.</p> <p>3. What Measures will be put into place or what system changes will you make to ensure that the deficient practice does not recur? - The facility Elopement Assessment, Risk and Prevention Policy includes notifying the attending physician with any elopement incidents and was reviewed by the Quality Assurance Team on 4/16/2025. - The Change in Condition Policy has been updated to include elopement incidents and attending physician notification. Nursing staff were educated on recognizing elopement and physician notification following any elopement incidents on 4/15/2025 and 4/16/2025.</p> <p>4. How will the corrective action be monitored to ensure that the deficient practice will not recur; i.e., what quality assurance programs will be established?</p>	

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F 0684 SS=D	Continued from page 3	F 0684	An Elopement Prevention Audit Tool, which includes physician notification, is being completed by the DON or designee daily for 2 weeks beginning on 4/16/2025, then weekly for 3 weeks, then monthly for 3 months, and then quarterly thereafter with the results reported to the Quality Assurance Committee for further follow-up. 5. Date of when the Corrective Action will be completed – May 16, 2025.	

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F 0684 SS=D	Continued from page 4 Based on review of facility policy, clinical records, and staff interview it was determined that the facility failed to notify a physician of elopements for one of four residents (Resident R1). Findings include: Review of the facility "Accident/Incident Reports, Residents" policy last reviewed 11/1/24, indicated that residents involved in an accident or incident are assessed by a licensed nurse and receive appropriate care with follow up care as indicated. The purpose is to ensure quality resident care and to prevent or treat complications. Notify physician and responsible party of any accident. The limit time for notification of physician or family will never be greater than twelve hours from the time of accident or incident. Review of Resident R1's clinical record indicated the resident was admitted to the facility on 3/4/21. Review of Resident R1's MDS (Minimum Data Set,	F 0684		

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F 0684 SS=D	Continued from page 5 periodic assessment of resident care needs) dated 3/5/25, indicated diagnoses of high blood pressure, dementia (a group of symptoms that affects memory, thinking and interferes with daily life), and cerebral infarction (necrotic tissue in the brain resulting loss of blood and oxygen to the brain). During a review of Resident R1's clinical record on 4/15/25, at 9:15 a.m. the following were identified: On 4/27/24, at 10:56 p.m. indicated resident found on ground level near the kitchen by the garbage dumpsters by the kitchen staff. Came back to second floor. Blaster was found in another room on the unit behind the closed door in her motorized wheelchair. Was redirected back to her room. Resident was very confused. The facility failed to notify the physician of this incident. On 5/18/24, at 1:10 a.m. revealed at the beginning of the shift writer observed resident in a non-electric wheelchair wheeling self-down the hallway. Writer inquired of evening nurse why the resident not using	F 0684		

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F 0684 SS=D	Continued from page 6 her electric wheelchair. Informed that two days ago, resident was found downstairs in a closet. Nurse stated, Mother had instructed her to keep the resident on the unit. Therefore, resident was assisted to a regular wheelchair for monitoring whereabouts. At 11:05 p.m. resident observed in the wheelchair and wandering down the hallway then back to her room. 11:20 p.m., again up in the hallway in her wheelchair. Offered her a snack with tea requested and hot tea given at table but, resident went back to her room. 12:25 a.m. resident returned to the table and drank her tea. At 12:45 a.m. returned to her room. Safety measures maintained. Call pendant around her neck. The facility failed to notify the physician this incident. On 5/26/24, at 11:09 p.m. reveled resident found on the first floor in her wheelchair. Was confused. Was escorted back to her unit. The facility failed to notify the physician of this incident. On 3/30/25, at 10:41 p.m. revealed resident found on first floor at reception desk by front door by	F 0684		

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F 0684 SS=D	Continued from page 7 staff. Was brought back up and returned to unit. Currently wandering on unit. Staff completed an Elopement Evaluation and Resident R1 scored a "2", indicating resident is at high risk for elopement. The facility failed to notify the physician of this incident. On 4/8/25, at 10:44 p.m. revealed resident wandered out in hallway by units then went over to another unit. Was returned to her room and given a snack. The facility failed to notify the physician of this incident. On 4/13/25, at 2:25 p.m. revealed resident found on the ground floor in the kitchen, by kitchen staff approximately 12:45 pm. Resident's wander guard on and functioning properly. No injuries noted. Unit supervisor aware and Mother. Room change was completed after this incident to the First floor where two out of four sets of doors have wander guard systems on them due to wandering behaviors. The facility failed to notify the physician of this incident.	F 0684		

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F 0684 SS=D	Continued from page 8 During an interview on 4/15/25, at 3:30 p.m. the Nursing Home Administrator and Director of Nursing confirmed that the facility failed to notify the physician of elopements for one of four residents (Resident R1), as required. 28 Pa. Code 201.18 (b)(1) Management 28 Pa. Code 201.29(a) Resident Rights 28 Pa. Code 211.10 (c)(d) Resident Care policies 28 Pa. Code 211.12 (d)(1)(2)(3)(5) Nursing services	F 0684		
F 0689 SS=J		F 0689		

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F 0689 SS=J	Continued from page 9 483.25(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. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? (Resident R1) - Resident R1 now has a Wander Guard and was moved to the first floor where the Wander Guard alarms are located. Resident R1 was assessed for injury and family was notified on 4/16/2025. The physician was notified of the elopement on 4/05/2025 at 16:30. 2. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? - Elopement risk assessments were completed on all residents on 4/16/2025. Any resident identified as at-risk for elopement was reviewed by the interdisciplinary team for appropriate interventions to prevent elopements. Sign-in/Sign-out sheets were initiated on 4/19/2025 to monitor all resident whereabouts on and off the nursing units.	Completion Date: 05/16/2025 Status: APPROVED Date: 05/05/2025

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F 0689 SS=J	Continued from page 10	F 0689	<p>3. What measures will be put into place or what system changes will you make to ensure that the deficient practice does not recur?</p> <p>The Elopement – Assessment, Risk & Prevention Policy was revised to include:</p> <ul style="list-style-type: none"> - Added that the Elopement Risk Assessment will be performed quarterly as part of the resident's care plan review. This is in addition to performing the assessment on admission (or readmission), for changes in the residents' condition or cognition, after an elopement attempt, upon verbalizing their desire to leave the facility, and any time a staff member feels that the resident should be reassessed. - Rounds were added on an hourly basis from 11:00 PM to 7:00 AM every night and every hour for weekend shifts. These rounds will be recorded in logbooks on every nursing unit. - Sign-in/Sign-out logs were added to every unit to update staff when 	

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F 0689 SS=J	Continued from page 11	F 0689	<p>the residents are off the unit for an activity, appointment, or outing.</p> <ul style="list-style-type: none"> - Binders are at every nursing station with at-risk resident photographs and their individualized care plans. - Binders are at the front desk with at-risk resident photographs. - In the event of an elopement, a full body assessment will be included. <p>All departments (agency and staff) were educated about elopement risks and procedures, that included recognizing elopement, completing risk assessments, care plans, supervision to prevent elopement, and the Wander Guard system. Further education will be ongoing and will be included in the new hire curriculum and at least annually with all staff education days.</p> <p>An emergency QAPI meeting was held on April 22, 2025, to review elopement policies and procedures. Another QAPI meeting is scheduled for May 5, 2025, to review elopement policies and procedures and progress with implementation. CNA meetings were held on April 22,</p>	

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F 0689 SS=J	Continued from page 12	F 0689	<p>2025, and a Licensed Nurse meeting was held on April 23, 2025, to educate clinical staff on the changes to the Elopement Policy and to discuss concerns.</p> <p>A Daily Stand-Up Meeting and Policy was developed and will begin on May 1, 2025. These meetings will review the 72-hour nursing report every Monday and will review the 24-hour nursing report every other weekday. The Stand-Up Meeting will address new business and reportables, high-risk review elements, and any events to be reported to the attending physicians and/or the medical director. A binder with the Stand-Up Meeting notes will be maintained by the nurse educator.</p> <p>Elopement drills will be held on at least a quarterly basis, with every shift evaluated on at least a yearly basis. An elopement drill is scheduled to be conducted on 5/02/2025.</p> <p>A directed In-Service on 42 CFR 483.25 Accidents/Hazard/Supervision F689</p>	

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F 0689 SS=J	Continued from page 13	F 0689	<p>will be held on May 7, 2025, by Masters crafted in Healthcare, LLC. This In-Service will include a review of all the federal regulations cited along with a review of the accompanying guidelines and be conducted on all shifts and recorded for any staff unable to attend. All staff will also be educated on new and revised policies at this time. The staff will continue to ensure that the new policies will be followed. This will be monitored at the daily Stand-Up Meetings, and audits of the rounding logbooks. All will be reported quarterly at QAPI.</p> <p>4. How will the corrective action be monitored to ensure that the deficient practice will not recur; i.e., what quality assurance programs will be established?</p> <p>The Elopement Prevention Audit Tool, which includes physician orders, treatment record documentation, elopement binders, incident reports, hourly logbooks, event reporting, and physician notification is being completed by the DON or designee daily for 2</p>	

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F 0689 SS=J	Continued from page 14	F 0689	weeks starting on 4/16/2025, then weekly for 3 weeks, then monthly for 3 months, and then quarterly thereafter with the results reported to the Quality Assurance Committee for further follow-up. 5. Dates of when the corrective action will be completed – May 16, 2025	

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F 0689 SS=J	Continued from page 15 Based on review of facility policy and documents, clinical records, and staff interviews, it was determined that the facility failed to make certain each resident received adequate supervision which resulted in an elopement (resident exits to an unsupervised or unauthorized area without the facility's knowledge) for one of four residents (Resident R1). This failure created an immediate jeopardy situation for one of four residents (Resident R1). Findings include: Review of the facility "Elopement Risk" policy last reviewed 11/1/24, indicated all residents are assessed for elopement risk and those found to be at risk will have a resident care plan that addresses this issue. Policy is to attempt to prevent incidents of elopement and to provide for the safety and well-being of all residents. A resident elopement risk assessment will be performed at the following times: - At time of admission	F 0689		

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F 0689 SS=J	Continued from page 16 - After an elopement attempt - Verbalizing desire to leave the facility - Anytime a staff member feels a need to reassess a resident In the event an incident of elopement the attending physician is made aware of the incident, the resident's representative or family is notified, an incident report is completed, staff will encourage activities that the resident enjoys in order to provide diversion to the resident. Review of Resident R1's clinical record indicated the resident was admitted to the facility on 3/4/21. Review of Resident R1's MDS (Minimum Data Set, periodic assessment of resident care needs) dated 3/5/25, indicated diagnoses of high blood pressure, dementia (a group of symptoms that affects memory, thinking and interferes with daily life), and cerebral infarction (necrotic tissue in the brain resulting loss of blood and oxygen to the brain). Review of Section C0500-BIMS screening	F 0689		

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F 0689 SS=J	Continued from page 17 indicated a score of "8," which indicated Resident R1 was moderately impaired. Review of Resident R1's admission Elopement Risk Assessment dated 3/7/21, revealed the assessment score was a four and placed resident as a moderate risk for elopement. Elopement Risk Assessment indicated that resident had no wandering episodes and walked independently. Review of Resident R1's physician order dated 3/5/21, indicated the resident may go on therapeutic leave with family/staff with medications. Review of Resident R1's clinical record indicated that she resided on the Second Floor in a private room. Review of documentation provided by the facility to the Department of Health on 4/6/25, indicated that a staff member (Activity Employee E9), who was leaving for the day, observed Resident R1 outside the building on the loading dock, walking down the	F 0689		

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F 0689 SS=J	Continued from page 18 steps towards the parking lot. Resident R1's wheelchair was noted to be sitting on the loading dock. Resident R1 was seen 15 minutes prior to the incident in her room where the nurse was administering her medication. Resident R1 had left the unit there after and made her way off the unit, to the ground floor and through the outside doors to exit the building. On the date of incident, resident was noted to be more confused than usual. Review of a progress note dated 4/5/25, at 5:22 p.m. revealed that the resident was brought to unit by activities staff, who stated that she found resident outside when she (staff) was leaving the parking lot. Staff says she found resident at the bottom of the loading zone stairs by the kitchen area on the north side of the building. Resident's wheelchair was at the top of the stairs and resident was at the bottom of the stairs holding on to the railing. Staff brought resident back to the unit in her wheelchair. Resident appeared unharmed but was scared. Resident reminded not to leave the unit, and especially not to go on the elevators. Director of Nursing (DON) and	F 0689		

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F 0689 SS=J	<p>Continued from page 19</p> <p>supervisor notified. Supervisor to notify resident's nephew. Incident report completed and faxed to physician office. New order received for a Wander Guard monitor to resident's right ankle.</p> <p>Review of Resident R1's physician orders failed to reveal check placement of wander guard, check function of wander guard, and when to replace the wander guard. No other interventions were implemented to increase resident supervision and increase resident safety. Resident R1's care plans were not updated.</p> <p>During a tour on 4/15/25, at 9:02 a.m. with the DON, revealed that the Second Floor of the facility failed to have wander guard alarms on the doors leading off the unit and that the general elevator that is used by residents and visitors fail to lock if someone is wearing a wander guard bracelet.</p> <p>Review of Resident R1's clinical record on 4/15/25, indicated that facility failed to complete an Elopement Risk Assessment from 3/7/21 through</p>	F 0689		

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F 0689 SS=J	Continued from page 20 3/29/25. Resident R1's most recent Elopement Risk Assessment was completed on 3/30/25, and 4/5/25, indicating she was at risk for elopement. During an interview on 4/15/25, at 9:45 a.m. Registered Nurse Assessment Coordinator Employee E8 stated that elopement risk assessments are completed upon admission and if they have a wander guard due to them being identified as a high elopement risk, then they would have an elopement risk assessment quarterly. During a review of the facility's Incident Report for Resident R1's elopement on 4/5/25, at 4:30 p.m., revealed Resident R1 was in her room at 4:15 p.m. receiving her evening medication. Resident left unit. Resident was found on back outside loading dock on steps, was very confused. No noted injuries. Wander guard placed on right lower leg. Family notified. Physician was notified. Resident calmed down afterwards after remaining with staff. Activity Employee E9 stated, "I was leaving work at 4:30 p.m. I witnessed Resident R1 at the bottom of the	F 0689		

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F 0689 SS=J	Continued from page 21 steps on the loading dock standing. Her wheelchair was at the top. No other witness statements were obtained. During an interview on 4/15/25, at 9:30 a.m. DON stated that the facilities video surveillance revealed resident entering the loading dock through the doors and was seen on the loading dock. The cement column blocked the view of resident walking down the steps. DON stated that the resident was more confused on that day and reported that Resident R1 stated she was scared when they found her. During a review of Resident R1's progress notes from 4/27/24 through 4/15/25 indicated the following: On 4/27/24, at 10:56 p.m. a progress note indicated resident was found on ground level near the kitchen by the garbage dumpsters by the kitchen staff. Came back to second floor. Laster was found in another room on the unit behind the closed door in her motorized wheelchair. Was redirected back to	F 0689		

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F 0689 SS=J	Continued from page 22 her room. Resident was very confused. During a review of Resident R1's clinical record indicated the facility failed to identify this incident as an elopement. Failed to complete a head-to-toe assessment. Failed to complete elopement risk assessment. Failed to notify family and physician. Care plans were not updated. No other interventions were implemented to increase resident supervision and increase resident safety. Facility failed to notify appropriate agencies of an elopement, as required. On 4/28/24, at 2:10 a.m. a progress note indicated staff reports that resident has been resting quietly in bed. At 2:00 a.m., writer rounded on resident and observed her laying quietly on her left side in bed. Recommend a wander guard device to her wheelchair due to reports of increased episodes of anxiety and confusion. Voice message of the same left for DON. Follow up with MD as warranted, as needed.	F 0689		

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F 0689 SS=J	Continued from page 23 During a review of Resident R1's clinical record indicated the facility failed to complete an Elopement Risk Assessment and failed to notify the physician. Care plans were not updated. No other interventions were implemented to increase resident supervision and increase resident safety. On 5/8/24, at 6:16 p.m. a quarterly occupational therapy (OT) screen completed revealed Resident R1 has been presenting with increased confusion and wandering, especially overnight. She was recently followed by OT for a plan of care due to an increased need for assistance with ADLs and transfers. While she did demonstrate the ability to perform required physical tasks, she remains unsteady and requires supervision for safety, cues, and redirection. She presented to therapy department in her power wheelchair wearing pajamas at 4:30 p.m. today, requesting water for a fellow resident. Due to cognitive deficits and limited carryover of education, no need for OT intervention identified at this time. Resident will continue to benefit from oversight and	F 0689		

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F 0689 SS=J	Continued from page 24 supervision of staff for safety and redirection. On 5/18/24, at 1:10 a.m. a progress note indicated at the beginning of the shift writer observed resident in a non-electric wheelchair wheeling self-down the hallway. Writer inquired of evening nurse why the resident not using her electric wheelchair. Informed that two days ago, resident was found downstairs in a closet. Nurse stated, Nursing Home Administrator had instructed her to keep the resident on the unit. Therefore, resident was assisted to a regular wheelchair for monitoring whereabouts. At 11:05 p.m. resident observed in the wheelchair and wandering down the hallway then back to her room. 11:20 p.m., again up in the hallway in her wheelchair. Offered her a snack with tea requested and hot tea given at table but, resident went back to her room. 12:25 a.m. resident returned to the table and drank her tea. At 12:45 a.m. returned to her room. Safety measures maintained. Call pendant around her neck. During a review of Resident R1's clinical record	F 0689		

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F 0689 SS=J	Continued from page 25 indicated the facility failed to identify an incident "from two days ago" as an elopement. No documentation completed for the alleged incident. Failed to complete a head-to-toe assessment. Failed to complete elopement risk assessment. Failed to notify family and physician. Care plans were not updated. No other interventions were implemented to increase resident supervision and increase resident safety. Facility failed to notify appropriate agencies of an elopement, as required. On 5/26/24, at 11:09 p.m. a progress note indicated the resident was found on the first floor in her wheelchair. Was confused. Was escorted back to her unit. During a review of Resident R1's clinical record indicated the facility failed to identify this incident as an elopement. Failed to complete a head-to-toe assessment. Failed to complete elopement risk assessment. Failed to notify family and physician. Care plans were not updated. No other interventions were implemented to increase resident	F 0689		

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F 0689 SS=J	Continued from page 26 supervision and increase resident safety. Facility failed to notify appropriate agencies of an elopement, as required. On 1/31/25, at 11:44 p.m. a progress note indicated the resident was attempting to elope. She is going to every door she sees to open it and get out. Staff explaining to her its late and everyone is sleeping, and all the doors are locked. So, at present time she is getting into bed. Monitoring. During a review of Resident R1's clinical record indicated the facility failed to complete an Elopement Risk Assessment due to exit seeking behaviors and failed to notify the physician. Care plans were not updated. No other interventions were implemented to increase resident supervision and increase resident safety. On 2/14/25, at 5:50 p.m. a Physical Therapy quarterly screen completed revealed, resident independent on unit with mobility in manual wheelchair, participated with ambulation 15 feet	F 0689		

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F 0689 SS=J	Continued from page 27 with no reports of decline in mobility at this time, no intervention needed at this time. On 2/17/25, at 2:19 p.m. revealed resident had a fall. On 2/28/25, at 12:40 p.m. a progress note indicated that resident was moving herself around unit via wheelchair, speaking to staff. Resident stated, "take me to work" "I have to get paid" "I have to go back home." Resident held her TV remote and asked staff to "call the timekeeper". Unit supervisor aware of resident's behavior. DON made aware, urine sample to be obtained. During a review of Resident R1's clinical record indicated the facility failed to complete an Elopement Risk Assessment due to exit seeking behaviors and failed to notify the physician. Care plans were not updated. No other interventions were implemented to increase resident supervision and increase resident safety.	F 0689		

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F 0689 SS=J	Continued from page 28 On 3/19/25, at 7:07 a.m. a progress note indicated that resident stayed up throughout night, trying many times to go out of the main door (on unit). Continue following behind staff, entering other resident rooms. Number of times noted and when: three to four times. Interventions/redirection attempted: Resident was reminded not to go to the door and was taken away from main door. Was reminded and taken away from other resident's room. Resident also cursed at the staff. When resident was praised. Evaluation of interventions: Resident was quiet down after praises. During a review of Resident R1's clinical record indicated the facility failed to complete an Elopement Risk Assessment due to exit seeking behaviors and failed to notify the physician. Care plans were not updated. No other interventions were implemented to increase resident supervision and increase resident safety. On 3/30/25, at 10:41 p.m. a progress note indicated that resident found on first floor at reception desk by	F 0689		

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F 0689 SS=J	Continued from page 29 front door by staff. Was brought back up and returned to unit. Currently wandering on unit. Staff completed an Elopement Evaluation and Resident R1 scored a "2", indicating resident is at high risk for elopement. During a review of Resident R1's clinical record indicated the facility failed to identify this incident as an elopement. Failed to complete a head-to-toe assessment. Failed to respond to a high-risk elopement risk assessment. Failed to notify family and physician. Care plans were not updated. No other interventions were implemented to increase resident supervision and increase resident safety. Facility failed to notify appropriate agencies of an elopement, as required. On 4/8/25, at 10:44 p.m. a progress note indicated that the resident wandered out in hallway by units then went over to another unit. Was returned to her room and given a snack. During a review of Resident R1's clinical record	F 0689		

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F 0689 SS=J	Continued from page 30 indicated the facility failed to identify this incident as an elopement. Failed to complete a head-to-toe assessment. Failed to complete an elopement risk assessment. Failed to notify family and physician. Care plans were not updated. No other interventions were implemented to increase resident supervision and increase resident safety. Facility failed to notify appropriate agencies of an elopement, as required. On 4/13/25, at 2:25 p.m. a progress note indicated that resident found on the ground floor in the kitchen, by kitchen staff approximately 12:45 pm. Resident's wander guard on and functioning properly. No injuries noted. Unit supervisor aware and Nursing Home Administrator. Room change was completed after this incident to the First floor where two out of four sets of doors have wander guard systems on them due to wandering behaviors. During a review of Resident R1's clinical record indicated the facility failed to identify this incident as an elopement. Failed to complete a head-to-toe	F 0689		

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F 0689 SS=J	Continued from page 31 assessment. Failed to complete an elopement risk assessment. Failed to notify family and physician. Care plans were not updated. No other interventions, other than room change, were implemented to increase resident supervision and increase resident safety. Facility failed to notify appropriate agencies of an elopement, as required. During a review of Resident R1's clinical record revealed the following: - On 5/15/24, Resident R1 was given a new diagnosis of Dementia. - On 6/20/24, BIMS score was "8", indicating moderately impaired. - On 3/5/25, BIMS score was "8", indicating moderately impaired. - On 4/15/25, An elopement risk assessment completed, indicating a "16", high risk for elopement. On 4/15/25, at 3:30 p.m. the Nursing Home Administer and DON were notified that Immediate	F 0689		

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F 0689 SS=J	Continued from page 32 Jeopardy was called due to the elopement of Resident R1 on 4/5/25. The Nursing Home Administer and DON were provided the Immediate Jeopardy template, and a corrective action plan was requested. On 4/15/25, at 7:42 p.m. an immediate action plan was received and accepted which included the following interventions: An elopement assessment will be done on every resident by 4/16/25, at 8:00 a.m. Resident R1 now has a wander guard and is moved to the first floor where the alarms are located. Resident R1 has been assessed for injury and family was notified of all the events. Elopement care plans, which include resident specific interventions, will be done on every resident by 4/16/25, at 8:00 a.m.	F 0689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 396116	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/16/2025	
NAME OF PROVIDER OR SUPPLIER: LITTLE SISTERS OF THE POOR STATE LICENSE NUMBER: 340302		STREET ADDRESS, CITY, STATE, ZIP CODE: 1028 BENTON AVENUE PITTSBURGH, PA 15212		
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F 0689 SS=J	Continued from page 33 Hourly rounds will be added to all night and weekend shifts. Wander guard placement will be checked every shift, and wander guard function will be checked daily. This can be found in the residents chart under doctor orders and treatment administration record. At risk residents must be supervised when out of bed by a staff member to ensure residents are safe. Educate all departments including agency by 12:00 p.m. on 4/16/25 on the following: - Elopement Risk and Assessment - Care plans - Supervision - Wander guards - How to activate wander guards and where they are located - Color light indicators Elopement policy revised 4/15/25, to add the	F 0689		

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F 0689 SS=J	Continued from page 34 following: - Head to toe assessment (full body) is added - Elopement risk assessments will be done quarterly with care plan review - Elopement binders will be on each nurse's station and front desk, to include picture and room number. Elopement binders on the nurse's station will include residents care plan and will be updated as needed. - All departments will be educated on elopement risk and assessment and will be added to the new hire training as well. Emergency Quality Assurance Performance Improvement (QAPI) meeting will be held 4/16/25 with all supervisors and committee members. All other incidents will be reviewed at regular QAPI meetings. Audits will be completed. On 4/16/25, at 8:35 a.m. all residents with wander	F 0689		

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F 0689 SS=J	Continued from page 35 guards had completed orders to include, location of wander guard, check placement every shift, check function daily, and wander guard light indicator mean. On 4/16/25 at 8:50 a.m., all resident assessments for elopement risk were reviewed and found to be completed, and care plans were reviewed and updated with resident specific interventions for 41 of 41 residents. On 4/16/25, the facilities audit tool was reviewed. Daily audits will be completed by DON or designee daily for two weeks, then weekly for three weeks, then monthly for three months, and then quarterly. On 4/16/25, the facilities Hourly Round tool was reviewed. Will be conducted at night and on the weekends. On 4/16/25, the facility called and emergency QAPI meeting, and signature sheet was provided and reviewed.	F 0689		

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F 0689 SS=J	Continued from page 36 During a tour of the facility on 4/16/25, elopement binders were observed on all nursing units and front desk with pictures and care plans that allow staff quick access to resident specific behaviors to aid in redirecting a resident. Staff education was verified with dated sign-in sheets and review of all current staff and agency staff utilized in the facility having signed and/or educated over the phone as indicated. During in-person and phone interviews completed from 4/16/25, at 1:20 p.m. until 4/16/25, at 2:16 p.m. 20/20 staff confirmed they were educated in person and 1/1 staff via phone. Staff were educated on how and when to complete an elopement assessment, and what to do for residents that are displaying exit seeking behaviors. Staff were educated on the updated elopement policy. Staff were educated on new elopement binders found at nurses ' station, and nursing staff was educated on activating and checking function of wander guards.	F 0689		

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F 0689 SS=J	Continued from page 37 All staff educated signed the education sheet. 105/127 staff members were educated. All other staff will be educated prior to their next shift and sign the education sheet. During an interview on 4/16/25, at 1:20 p.m. Nursing Assistant (NA) Employee E1 stated, "I thought the education was educational and learned a lot". During an interview on 4/16/25, at 1:28 p.m. NA Employee E2 stated, "I like the Elopement binder. It has all their pictures in and interventions in the care plan. Very informative". During an interview on 4/16/25, at 1:37 p.m. NA Employee E3 stated, "I learned how to redirect residents and to report residents who are able to leave the unit and when they come back to the supervisor". During an interview on 4/16/25, at 1:44 p.m. Maintenance Employee E5 stated, "I know the	F 0689		

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F 0689 SS=J	Continued from page 38 definition of elopement now". During an interview on 4/16/25, at 2:01 p.m. Registered Nurse Employee E6 stated, "The education was definitely worthwhile. Good to review things, everyone needs reminders". During an interview on 4/16/25, at 2:10 p.m. Social Service Employee E7 stated, "I liked learning what to do, which residents are at higher risk and that you can see resident specific interventions in their care plans". Verification of the facility's Corrective Action Plan revealed all elements of plan were met. The Immediate Jeopardy was lifted on 4/16/25, at 3:19 p.m. During an interview on 4/15/25, at 3:30 p.m., the Nursing Home Administrator and DON confirmed that the facility failed to provide adequate supervision resulting in Resident R1's elopements. This failure created an immediate jeopardy situation	F 0689		

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F 0689 SS=J	Continued from page 39 for Resident R1 and potentially put her at risk of harm or injury. 28 Pa. Code 201.14(a) Responsibility of Licensee. 28 Pa. Code 201.18 (e)(1)(3) Management. 28 Pa. Code 211.10(c)(d) Resident care policies. 28 Pa. Code 211.12 (c)(d)(3)(5) Nursing services.	F 0689		

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F 0835 SS=D		F 0835		

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F 0835 SS=D	Continued from page 41 483.70 Administration §483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by:	F 0835	1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? The Nursing Home Administrator and the Director of Nursing reviewed their job descriptions with the Human Resources Director, with a focus on the essential job functions. The Nursing Home Administrator completed her review on 4/30/2025. The Director of Nursing completed her review on 5/01/2025. 2. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? The Nursing Home Administrator and the Director of Nursing will attend the directed In-Service on 42 CFR 483.25 Accidents/Hazard/Supervision F689, which will be held on the week of May 5, 2025, by Masters crafted in Healthcare, LLC. This In-Service will include a review of all the federal	Completion Date: 05/05/2025 Status: APPROVED Date: 05/03/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 396116	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/16/2025
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F 0835 SS=D	Continued from page 42	F 0835	<p>regulations cited along with a review of the accompanying guidelines. The Elopement Assessment, Risk, and Prevention Policy was updated to include the definition of elopement. New policies were developed and implemented on Investigating and Reporting Accidents and Incidents, for both Administration and Nursing Staff.</p> <p>3. What measures will be put into place or what system changes will you make to ensure that the deficient practice does not recur?</p> <p>The Nursing Home Administrator and Director of Nursing will continue to ensure that the new policies will be followed. This will be monitored at the daily Stand-Up Meetings, through audits of the electronic medical records. All will be reported quarterly at QAPI.</p> <p>4. How will the corrective action be monitored to ensure that the deficient practice will not recur; i.e., what quality assurance programs will</p>	

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F 0835 SS=D	Continued from page 43	F 0835	<p>be established?</p> <p>The Nursing Home Administrator and Director of Nursing are in attendance at each morning Stand-Up Meeting where resident specific issues and outcomes are reviewed.</p> <p>The Elopement Prevention Audit Tool, which includes physician orders, treatment record documentation, elopement binders, incident reports, hourly logbooks, event reporting, and physician notification is being completed by the DON or designee daily for 2 weeks starting on 4/16/2025, then weekly for 3 weeks, then monthly for 3 months, and then quarterly thereafter with the results reported to the Quality Assurance Committee for further follow-up.</p> <p>5. Dates of when the corrective action will be completed – May 16, 2025</p>	

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F 0835 SS=D	Continued from page 44 Based on review of job descriptions, clinical records and staff interviews, it was determined that the Nursing Home Administrator (NHA) and the Director of Nursing (DON) failed to effectively manage the facility to prevent the elopements of a resident (Resident R1). Findings include: The job description for the Nursing Home Administrator dated 10/3/23, indicated the NHA collaborates with the Little Sisters of the Poor to coordinate, direct develop, and maintain various programs within all departments of the home. He or she will work together to ensure adherence to policies and procedures. NHA will direct and guide the performance of others. Knowledge of all relevant federal and state rules and regulations governing long-term care facilities and the ability to properly interpret these. The job description for the Director of Nursing dated 10/1/24, indicated the DON is responsible for	F 0835		

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F 0835 SS=D	<p>Continued from page 45</p> <p>the development and maintenance of nursing service objectives, standards of nursing practice, nursing policy and procedure manual. DON must have thorough knowledge of state and federal regulations that govern a long-term facility. Oversee initiation and implementation of a plan of care for each resident and that it is reviewed and modified as indicated.</p> <p>Based on findings identified in this report, the facility failed to prevent the elopement of a resident (Resident R1), which placed the residents in Immediate Jeopardy. The NHA and the DON failed to fulfill their essential job duties to ensure the federal and state guidelines and regulations were followed.</p> <p>During an interview on 4/15/25, at 3:30 p.m. the NHA and DON were notified that they failed to effectively manage the facility to prevent the elopement of a resident.</p> <p>28 Pa. Code 201.14(a) Responsibility of licensee.</p>	F 0835		

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F 0835 SS=D	Continued from page 46 28 Pa. Code 201.18(b)(1)(3)(e)(1) Management. 28 Pa. Code 211.12(d)(1)(2)(3)(5) Nursing services.	F 0835			

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H 0009		H 0009		

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: 396116	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/16/2025
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H 0009	Continued from page 1 51.3 (g)(1-14) NOTIFICATION 51.3 Notification (g) For purposes of subsections (e) and (f), events which seriously compromise quality assurance and patient safety include, but not limited to the following: (1) Deaths due to injuries, suicide or unusual circumstances. (2) Deaths due to malnutrition, dehydration or sepsis. (3) Deaths or serious injuries due to a medication error. (4) Elopements. (5) Transfers to a hospital as a result of injuries or accidents. (6) Complaints of patient abuse, whether or not confirmed by the facility. (7) Rape. (8) Surgery performed on the wrong patient or on the wrong body part. (9) Hemolytic transfusion reaction. (10) Infant abduction or infant discharged to the wrong family. (11) Significant disruption of services due to disaster such as fire, storm, flood or other occurrence.	H 0009	The facility reported the elopement to the DOH on 4/5/25. The facility developed an Event Reporting Policy that includes an outline of the incidents and events that are required to be reported per Chapter 51.3. The facility updated its Change in Condition Policy to include elopement incidents and the required reporting and follow-up. All departments (Agency and staff) were educated about elopement risks and procedures, that included recognizing elopement and reporting of elopement incidents immediately to their immediate supervisor and then the Nursing Home Administrator and Director of Nursing. This education will also be included in the new hire curriculum and at least annually with all staff education days. The Elopement Prevention Audit Tool, which includes physician orders, treatment record documentation, elopement binders, incident reports, hourly logbooks, event reporting, and physician notification is being completed by	Completion Date: 05/16/2025 Status: APPROVED Date: 05/05/2025

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H 0009	Continued from page 2 (12) Notification of termination of any services vital to continued safe operation of the facility or the health and safety of its patients and personnel, including, but not limited to, the anticipated or actual termination of electric, gas, steam heat, water, sewer and local exchange of telephone service. (13) Unlicensed practice of a regulated profession. (14) Receipt of a strike notice. This REGULATION is not met as evidenced by:	H 0009	the DON or designee daily for 2 weeks starting on 4/16/2025, then weekly for 3 weeks, then monthly for 3 months, and then quarterly thereafter with the results reported to the Quality Assurance Committee for further follow-up. Completion date – May 16, 2025	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 396116	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/16/2025
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(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
H 0009	Continued from page 3 Based on facility reports, and staff interviews it was determined that the facility failed to notify the Department of Health of six of seven reportable events of elopements (Resident R1). Findings include: Review of the facility "Accident/Incident Reports, Residents" policy last reviewed 11/1/24, indicated that residents involved in an accident or incident are assessed by a licensed nurse and receive appropriate care with follow up care as indicated. The purpose is to ensure quality resident care and to prevent or treat complications. Notify physician and responsible party of any accident. The limit time for notification of physician or family will never be greater than twelve hours from the time of accident or incident. Review of Resident R1's clinical record indicated the resident was admitted to the facility on 3/4/21. Review of Resident R1's MDS (Minimum Data Set,	H 0009		

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H 0009	Continued from page 4 periodic assessment of resident care needs) dated 3/5/25, indicated diagnoses of high blood pressure, dementia (a group of symptoms that affects memory, thinking and interferes with daily life), and cerebral infarction (necrotic tissue in the brain resulting loss of blood and oxygen to the brain). During a review of Resident R1's clinical record on 4/15/25, at 9:15 a.m. the following were identified: On 4/27/24, at 10:56 p.m. indicated resident found on ground level near the kitchen by the garbage dumpsters by the kitchen staff. Came back to second floor. Blaster was found in another room on the unit behind the closed door in her motorized wheelchair. Was redirected back to her room. Resident was very confused. The facility failed to notify appropriate agency of an elopement, as required. On 5/18/24, at 1:10 a.m. revealed at the beginning of the shift writer observed resident in a non-electric wheelchair wheeling self-down the hallway. Writer	H 0009		

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H 0009	Continued from page 5 inquired of evening nurse why the resident not using her electric wheelchair. Informed that two days ago, resident was found downstairs in a closet. Nurse stated, Mother had instructed her to keep the resident on the unit. Therefore, resident was assisted to a regular wheelchair for monitoring whereabouts. At 11:05 p.m. resident observed in the wheelchair and wandering down the hallway then back to her room. 11:20 p.m., again up in the hallway in her wheelchair. Offered her a snack with tea requested and hot tea given at table but, resident went back to her room. 12:25 a.m. resident returned to the table and drank her tea. At 12:45 a.m. returned to her room. Safety measures maintained. Call pendant around her neck. The facility failed to notify appropriate agency of an elopement, as required. On 5/26/24, at 11:09 p.m. reveled resident found on the first floor in her wheelchair. Was confused. Was escorted back to her unit. The facility failed to notify appropriate agency of an elopement, as required.	H 0009		

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H 0009	Continued from page 6 On 3/30/25, at 10:41 p.m. revealed resident found on first floor at reception desk by front door by staff. Was brought back up and returned to unit. Currently wandering on unit. Staff completed an Elopement Evaluation and Resident R1 scored a "2", indicating resident is at high risk for elopement. The facility failed to notify appropriate agency of an elopement, as required. On 4/8/25, at 10:44 p.m. revealed resident wondered out in hallway by units then went over to another unit. Was returned to her room and given a snack. The facility failed to notify appropriate agency of an elopement, as required. On 4/13/25, at 2:25 p.m. revealed resident found on the ground floor in the kitchen, by kitchen staff approximately 12:45 pm. Resident's wander guard on and functioning properly. No injuries noted. Unit supervisor aware and Mother. Room change was completed after this incident to the First floor where two out of four sets of doors have wander guard systems on them due to wandering behaviors. The	H 0009		

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H 0009	Continued from page 7 facility failed to notify appropriate agency of an elopement, as required. During an interview on 4/15/25, at 3:30 p.m. the Nursing Home Administrator and Director of Nursing confirmed that the facility failed to notify the Department of Health of six of seven reportable events of elopements, as required.	H 0009		

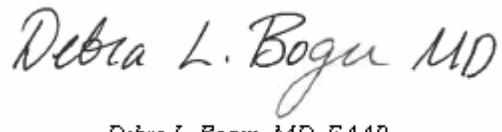


Certified End Page

LITTLE SISTERS OF THE POOR
STATE LICENSE NUMBER: 340302
SURVEY EXIT DATE: 04/16/2025

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


Jeanne Parisi
Deputy Secretary for Quality Assurance


Debra L. Bogen, MD, FAAP
Secretary of Health



Pennsylvania
Department of Health

THIS IS A CERTIFICATION PAGE

PLEASE DO NOT DETACH

THIS PAGE IS NOW PART OF THIS SURVEY