STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395090	A. BUILDING _____ B. WING _____	**07/06/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WINDBER WOODS SENIOR LIVING & REHABILITATION CTR	**277 HOFFMAN AVENUE WINDBER, PA 15963**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0604 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment.** Based on review of facility policies, investigative documents, and residents' clinical records, as well as staff interviews, it was determined that the facility failed to ensure that residents were free from abuse caused by physically restraining one of seven residents reviewed (Resident 4), when it was not required to treat the resident's medical symptoms. Findings include: The facility's abuse policy, dated February 2020, indicated that each resident had a right to be free from abuse, and that no resident would have physical or chemical restraints imposed for purposes of discipline or convenience. An incident investigation, dated April 29, 2020, indicated that while Nurse Aide 1 was attempting to place Resident 4's legs into his bed, the resident kicked the nurse aide in the chin, and Nurse Aide 2 came into the room to assist. Nurse Aide 1 then saw Nurse Aide 2 holding Resident 4's arms and legs down on the bed and Resident 4 was unable to move. A statement obtained by the facility from Nurse Aide 2, dated April 29, 2020, revealed that Nurse Aide 2 got on top of Resident 4 and held his arms and legs down to prevent the resident from striking or kicking the nurse aide (Nurse Aide 1). He further stated that he was aware that what he did was considered a restraint and was against the company's policy regarding abuse. Interview with the Director of Nursing on May 12, 2020, at 10:20 a.m. revealed that Nurse Aide 2 received annual education regarding abuse since his hire date in 2003, and most recently received abuse training on April 14, 2020. 28 Pa. Code 211.8(a) Use of restraints.

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.