STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	396067	A. BUILDING _____ B. WING _____	**03/11/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CONCORDIA AT REBECCA RESIDENCE	**3746 CEDAR RIDGE ROAD ALLISON PARK, PA 15101**

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

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F 0580 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of facility policies and documents and staff interviews it was determined that the facility failed to notify the physician of a resident's change in condition for one of three closed records (Resident CR9). Findings include: A review of facility Change in Resident Condition or Status, Physician and Family Notification policy dated 12/30/19, indicated that the nurse immediately informs the resident, physician and legal representative/responsible party when the resident has had a significant change in physical, mental or psychosocial status. Nursing staff is responsible for documenting the resident's change in condition, notification of physician, family, legal representative or resident. A review of the Admission Face Sheet indicated that Resident CR9 was admitted to the facility with the [DIAGNOSES REDACTED]. was notified of a change in the condition status of the resident. The daughter gave permission for the facility to send the resident out to the hospital for evaluation. The progress notes further indicated that the facility called for an ambulance and the resident was transferred to the hospital for evaluation. The progress notes failed to provide evidence that the physician was notified of the resident being transferred to the hospital. A review of the progress notes for Resident CR9 dated 3/4/2020, indicated that the resident left the facility by ambulance at 9:35 p.m. and that the resident was admitted to the hospital on [DATE]. A review of physician order [REDACTED]. in condition and obtain a physician order [REDACTED]. The facility obtained the physician order [REDACTED]. 28 Pa. Code: 201.29(a) Resident rights.
F 0609 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, clinical records and facility grievance reports and staff interviews, it was determined that the facility failed to make certain that all allegations of abuse, neglect and misappropriation of property were reported immediately, but not later than two hours after the allegation was made to the state survey agency as required for five of 11 residents (Resident R200, CR202, CR203, CR204 and CR205). Findings include: The facility policy Abuse, Alleged Resident, Neglect or Misappropriation of Property dated 12/3/18, and last reviewed by the facility on 12/30/19, indicated that when an incident of abuse, neglect, exploitation and mistreatment was alleged or suspected the facility would immediately, but not later than two hours after the allegation is made would notify the Department of Health office by electronic submission. During an interview on 3/8/2020, at 1:32 p.m. Resident R200's daughter revealed that she felt that her father was neglected while being provided a shower as he was non weight bearing on his right side and a Nursing Assistant (NA) stood him up and had him apply weight to his right side. A review of the facility Grievance/Complaint Report dated 2/27/2020, revealed that Resident R200's daughter made an allegation of neglect when the facility failed to make certain that the resident's non weight bearing on his right side was maintained. The allegation stated that a NA had the resident stand while providing him with a shower, applying weight to the resident's right side. During an interview of 3/11/2020, at 11:17 a.m. the Director of Nursing confirmed that the facility investigated the allegation of neglect for Resident R200 but failed to notify the Sate survey agency of the alleged violation as required. A review of the Face Sheet indicated that Resident CR202 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. A nurse note dated 3/12/19, indicated that Resident CR202 was transferred to the hospital. A grievance report dated 3/13/19, indicated that Resident Family Member CR202 phoned the facility and reported that hospital personnel found a bedsore on (resident's) backside and the family member was upset that they were not made aware. A review of the Face Sheet indicated that Resident CR203 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. A grievance report dated 6/1/19, indicated that Resident Family Member CR203 was upset that the resident had a bowel movement in bed due to staff not responding to activated call bell and alleged This is abuse and they are abusing my husband. A review of the Face Sheet indicated that Resident CR204 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. A grievance report dated 7/7/19, indicated that Resident CR204 named a nurse and reported that this nurse consistently wants to find a reason to either give my pain medication late or not at all. The resident reported that nurse refused to give it, told the resident the nurse could lose her license or told her to ask another nurse. A review of the Face Sheet indicated that Resident CR205 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. A grievance report dated 12/20/19, indicated that Resident CR205 reported that $90.00 was missing from the top drawer of the resident's bedside cabinet. During an interview on 3/10/20, at 1:45 p.m. the Nursing Home Administrator, Director of Nursing and Assistant Director of Nursing Employee E1 confirmed that the facility failed to make certain that Residents CR202, CR203, CR204 and CR205 allegations of neglect, abuse and/or misappropriation of property, although investigated by the facility, were reported to the state survey agency as required. 28 Pa. Code: 201.14(a) Responsibility of licensee. Previously cited 2/26/19. 28 Pa. Code: 201.14(c)(e) Responsibility of licensee. 28 Pa. Code: 201.18(a)(b)(1) Management.
F 0730 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Observe each nurse aide's job performance and give regular training.** Based on review of facility staff performance evaluations, and training records it was determined that the facility failed to conduct timely annual performance evaluations for six of six employees (Nurse Aide (NA) Employee E5, E12, E13, E14, E15 and E16) and make certain that staff received the required number of annual training hours for five of six employees (NA Employee E12, E13, E14, E15 and E16). Findings include: Review of facility Performnce evaluations on 3/10/2020, it was revealed that the facility failed to complete an annual performance evaluation in 2019 for NA Employees E5, E12,E13, E14, E15 and E16. A review of the facility training records on 3/10/2020, revealed the following: - NA Employee E12 for the training period of 5/18, through 5/19, failed to receive any training hours as required. - NA Employee E13 for the training period of 2/18, through 2/19, failed to receive any training hours as required. received nine hours and 40 minutes of training which was less than the 12 hours required. - NA Employee E14 for the training period of 6/18, through 6/19, received three hours of training which was less than the 12 hours required. - NA Employee E15 for the training period of 4/18, through 4/19, failed to receive any training hours as required. - NA Employee E16 for the training period of 5/18, through 5/19, received two hours of training which was less than the 12 hours required. During an interview on 3/10/2020, at 11:30 a.m. the Nursing Home Administrator confirmed that the facility had not completed annual Employee Performance Evaluations for the year 2019 for NA Employee E5, E12, E13, E14, E15 and E16 and failed to make certain that NA Employee E12, E13, E14, E15 and E16 received 12 hours of annual training as required. 28 Pa Code 201.20(a)(c)(d) Staff development.
F 0807 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure each resident receives and the facility provides drinks consistent with resident**

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.

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F 0807 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 1) **needs and preferences and sufficient to maintain resident hydration.** Based on review of facility policy and resident council meeting minutes, observation and resident, family and staff interviews, it was determined that the facility failed to consistently make certain that fresh water was readily accessible to residents on two of two nursing units (First floor and Second floor nursing units). Findings include: The facility policy Water Pitchers/Ice Pass dated 12/3/18, and last reviewed 12/30/19, indicated that fresh ice was provided to residents who had no fluid restrictions on each shift. A review of the resident council meeting minutes dated 6/23/19, indicated that a resident requested that staff make sure their water pitcher in their room was filled. During an interview on 3/8/20, at 10:45 a.m. Resident Family Member RF500 reported that I'm at the facility every day and cannot recall seeing staff consistently passing fresh water. I ask when (resident's) pitcher is empty. During an interview on 3/8/20 at 11:05 a.m. Resident R501 said that staff are not good at providing fresh water unless you ask for it . The resident denied seeing staff passing fresh water/pitchers each shift. During an observation on 3/8/20, at 11:05 a.m. Resident R501 had no water pitcher at her bedside. During an interview on 3/8/20 at 11:27 a.m. Resident Family Member RF502 reported I'm here everyday and can't say I've seen staff passing water .I usually get my (resident's) pitcher filled. During a resident group meeting on 3/10/20, at 2:30 p.m. Residents R503, R504, R505, R506, R507, R508, R509 and R510, who resided on both the First floor and Second floor nursing units, reported that they do not consistently get fresh water unless they ask for it. Resident R510 reported I got a pitcher the day after I was admitted and reported that getting water must be a problem because I heard a resident in therapy today say that they finally got a water pitcher after being without one for two weeks. During interviews on 3/10/20, at 10:30 a.m. and at 11:10 a.m. Nurse Aide Employee E4 and E5 confirmed that they failed to consistently provide fresh water on every shift because, although important, sometimes other things take priority. 28 Pa. Code: 201.29(j) Resident rights. 28 Pa. Code: 211.12(a)(c) Nursing services. 28 Pa. Code: 211.12(d)(3)(5) Nursing services. Previously cited 2/26/19.
F 0812 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.** Based on review of facility policies, observations and staff interviews it was determined that the faciltiy failed to maintain food equipment in a clean, sanitary condition, perform proper hand washing, and maintain the proper chemical strength for the chemical sanitizer at the manual warewashing three compartment sink in the Main Kitchen. (Main Kitchen) Findings include: A review of the facility General Food Preparation and Handling policy dated 1/22/2020, indicated that all food service equipment is cleaned, sanitized, dried and reassembled after each use. A review of the facility Employee Sanitary Practices policy dated 1/22/2020, indicated employee wash their hands before handling food. A review of the facility Hand Washing policy dated 1/22/2020, indicated that the staff will wash hands frequently as needed throughout the day following proper hand washing procedures. Hand washing is performed during food preparations, as often as necessary to remove soil and contamination and to prevent cross contamination when changing tasks and after engaging in other activities that contaminate the hands. During an observation of the Main Kitchen on 3/8/2020, at 9:47 a.m. it was revealed that the deep fryer contained a build up of food debris floating on top of the grease, the drain board and the edges around the fryer also contained a build up of food debris. During an interview on 3/8/2020, at 9:50 a.m. Cook Supervisor Employee E6 confirmed that the deep fryer contained a build up of food debris, the last day it was used for food preparation was on 3/7/2020, and that the facility failed to properly maintain the equipment in a clean and sanitary condition. During an observation of the tray line operation on 3/9/2020, at 11:19 a.m. it was observed that Cook Employee E7 with gloved hands used a soiled terry cloth towel that had been sitting on the counter top on the serving line to retrieve a tray of cooked hamburgers, with the same gloved hands he proceeded to touch hamburger buns, leaf lettuce and tomato slices without performing proper hand washing. While preparing a grilled cheese sandwich, with gloved hands he touched the control knobs on the stove to turn on the stove top, retrieved a container of liquid margarine, opened the container, poured margarine into a skillet, resealed the container, and then proceeded to unwrap a prepared grilled cheese sandwich, touching the sandwich while placing into the skillet using the same gloved hands and without performing proper hand washing. During an observation of the tray line operation on 3/9/2020, at 11:19 a.m. it was observed that Dietary Aide Employee E8 with gloved hands touched the outside of a package of thermal bowl lids, retrieved lids from the package, retrieved a thermal bowl from a bin by placing his gloved thumb inside the bowl. He proceeded to portion soup into the bowl, cover it with a lid and place it on the resident's tray without changing gloves or performing proper hand washing. During an observation of the testing of the chemical strength of the sanitizing solution at the manual warewashing three compartment sink on 3/10/2020, at 9:15 a.m. Corporate Food Service Manager Employee E9 tested the chemical strength of the sanitizing solution and obtained a reading of 100 part per million (ppm). He confirmed that the chemical strength was under the required 200 ppm and that he was going to request a service visit from the facility's chemical supplier to correct the chemical strength. During an interview on 3/10/2020, at 10:42 a.m. the information of the potential for cross contamination during tray line operations and the improper chemical strength of the sanitizing solution was presented to the Dietary Manager Employee E10. Dietary Manager Employee E10 confirmed that the presented information created the potential for cross contamination. 28 Pa. Code 211.6(c)(f) Dietary services.
F 0814 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Dispose of garbage and refuse properly.** Based on review of facility policies, observations, and staff interviews it was determined that the facility failed to dispose of rubbish in a manner to prevent the potential of rodent and pest infestation at the inside and outside disposing areas. (Inside and Outside Disposing Areas). Findings include: A review of the facility Waste Disposal policy dated 1/22/2020, indicated that all garbage will be disposed of daily. All waste will be kept in covered containers. Trash will be deposited into the sealed container outside the premises. A review of the facility Food Safety - Dietary Manager's Responsibilities policy dated 1/22/2020, indicated that proper waste methods are used and trash container are kept covered. During an observation on 3/8/2020, at 9:47 am garbage from the nursing units was placed into two uncovered garbage bins located on the inside of the facility at the receiving dock door. The facility places the garbage from the housekeeping and dietary departments in an uncovered dump truck located at the facility receiving dock. During an interview on 3/8/2020, at 9:50 a.m. Cook Supervisor employee E6 confirmed that the two garbage bins located inside the facility at the receiving dock door contained garbage bags to the top of the bins and the bins were uncovered. The dump truck located at the receiving dock of the facility was uncovered and contained garbage bags to the top of the truck dump bed. During an interview on 3/9/2020, at 8:52 a.m. Maintenance Director Employee E11 confirmed that the facility procedure for garbage disposal included utilizing an uncovered dump truck to transport garbage to the facility compactor located at the end of the facility parking lot. Garbage is transported on Friday at 4:30 p.m. and then not again until Sunday at 10:00 a.m. and during this timeframe the garbage is uncovered at the inside and outside disposing areas. The Maintenance Director Employee E11 confirmed that the facility failed to properly dispose of garbage to prevent the potential for pest and rodent infestation. 28 PA. Code: 207.2(a) Administator's responsibility.