STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395812	A. BUILDING _____ B. WING _____	**03/10/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LAURELWOOD CARE CENTER	**100 WOODMONT ROAD JOHNSTOWN, PA 15905**

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 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 clinical record reviews and staff interviews, it was determined that the facility failed to ensure that the resident's physician was notified timely about a change in condition for one of five residents reviewed (Resident 3). Findings include: The facility's policy regarding physician notification, dated December 16, 2019, indicated that the physician would be notified in a timely manner when a change in resident condition or an unusual incident involving the resident occurred. A nursing note for Resident 3, dated February 6, 2020, at 2:01 p.m. revealed that the nurse was called into the resident's room by activities and the resident was sitting up in a wheelchair complaining of mid-sternal chest pain that was non-radiating. The resident denied any shortness of breath. The physician was contacted and paged. A nursing note at 2:08 p.m. revealed that the resident stated that her pain was starting to ease up and the nurse was still waiting for the doctor. There was no further documented evidence that the physician was contacted regarding Resident 3's episode of chest pain until a nursing note dated February 7, 2020, at 10:19 a.m. revealed that the nurse spoke with the physician regarding the resident's onset of chest pain yesterday. New orders were received for [MEDICATION NAME] (a medication to treat chest pain) 0.3 milligram (mg) every five minutes for three doses, a chest x-ray, and an electrocardiogram (EKG - a test that measures the electrical activity of the heart) that day to evaluate chest pain. Interview with the Director of Nursing on March 6, 2020, at 2:30 p.m. revealed that she would have kept trying to contact Resident 3's physician. At 3:54 p.m. the Director of Nursing indicated that the resident's pain was subsiding, so that is why staff did not contact the physician. 28 Pa. Code 211.12(d)(3) Nursing services. 28 Pa. Code 211.12(d)(5) Nursing services.
F 0585 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.** Based on review of policies, clinical records, and facility grievance forms, as well as staff interviews, it was determined that the facility failed to make ongoing efforts to resolve the grievances of residents and/or their legal representatives for one of five residents reviewed (Resident 5). Findings include: The facility's grievance policy, dated December 16, 2019, indicated that the facility would investigate all grievances and complaints filed with the facility. Upon receipt of a grievance and complaint report, the grievance official was to determine the status of the investigation and either begin or continue an investigation into the allegations. Resident Council meeting minutes, dated January 10, 2020, revealed that Resident 5 stated that she did not receive her shower on her scheduled shower day that week. She also stated that there were issues with timeliness of staff answering call bells and with her bed pan on one occasion. The minutes indicated that the Director of Social Services captured these issues as a grievance as well and they would be addressed by the Director of Nursing and nursing staff. A grievance/complaint form for Resident 5, dated January 13, 2020, revealed that the resident indicated that on many mornings the food was cold and she did not receive coffee, sometimes the resident waited too long for call bells to be answered, once a nurse aide put a new pad over a wet pad, not all staff did a good job with bed baths, and the resident waited one week for her shower and it was not her regular shower day. There was no documented evidence of prompt efforts to resolve Resident 5's complaint/grievance regarding the bed pan, including an investigation, with interviews and/or written statements from the staff who worked during the day(s) in question, and whether or not there were enough staff to provide proper care during those times. Resident Council meeting minutes, dated February 14, 2020, revealed that Resident 5 continued to experience issues with her showers and the timeliness of her call bells, and new grievances were filed on her behalf. The resident also stated she had issues with the timeliness of getting on and off the bedpan and getting her ordered treatments, and a detailed grievance was filed with her concerns. There was no documented evidence of prompt efforts to resolve Resident 5's complaints/grievances regarding her continuing and new issues, including an investigation, with interviews and/or written statements from the staff who worked during the day(s) in question, and whether or not there were enough staff to provide proper care during those times. Interviews with the Director of Social Services on March 6, 2020, at 4:05 p.m. and 4:54 p.m. confirmed that there was no documented evidence that the grievances from Resident 5 on January 10 and February 14, 2020, were thoroughly investigated. 28 Pa. Code 201.29(i) Resident rights.
F 0609 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.** Based on review of Pennsylvania laws, the facility's policies, and residents' clinical records, as well as staff interviews, it was determined that the facility failed to ensure that all alleged violations involving abuse were reported to the State Survey Agency (Department of Health) and to other state agencies in accordance with state law for one of five residents reviewed (Resident 3). Findings include: The Older Adult Protective Services Act of November 6, 1987, amended by Act 1997-13, Chapter 7, Section 701, requires that all administrators or employees who have reasonable cause to suspect that a resident is a victim of sexual abuse, that abuse/neglect resulted in serious physical injury and/or serious bodily injury, or that a death was suspicious, were to make an immediate report to the Protective Services Agency, the Pennsylvania Department of Aging (PDA), and to law enforcement officials. The facility's policy regarding resident abuse, dated December 16, 2019, revealed that facility staff were to report any allegation or suspicion of abuse, neglect, exploitation, or the misappropriation of resident property immediately to their immediate supervisor. The facility was to report all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, following federal and state regulations. There was to be immediate notification, but no later than two hours, to the facility's administrator, the Department of Health - Division of Nursing Care Facilities, Area Agency on Aging, and Protective Services if the events that caused the allegation involved abuse or resulted in serious bodily injury, and notification within 24 hours if the events that caused the allegation did not involve abuse and did not result in serious bodily injury. An admission Minimum Data Set (MDS) assessments (a federally-mandated assessment of a resident's abilities and care needs) for Resident 3, dated February 8, 2020, revealed that the resident was understood, could understand, and required extensive assistance from staff for daily care tasks, including toileting. A nursing note for Resident 3, dated February 5, 2020, at 7:12 a.m., that was entered as incomplete documentation, revealed that the writer (Registered Nurse 1) was summoned by the nurse aides to the resident's room at

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 0609 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) approximately 6:45 a.m. The resident was found sitting in her bed in the same clothing she was wearing the day before, her clothing and bed linens were saturated with urine, and she was upset and crying. When the nurse aide staff rolled the resident to change her bedding, they found that the resident was sitting on a bed pan. The resident was not sure who placed her on the bed pan, but stated that she had been on it for quite some time, and she rang several times to be changed and use the bathroom, but no one came. The resident's skin on her buttocks was not broken or cut by the bedpan, but there was a very deep, prominent indentation in her skin, leaving an impression of the bedpan. A nursing note for Resident 3, dated February 6, 2020, at 8:15 a.m. and completed by the Director of Nursing, revealed that she spoke with the resident and the resident's family member regarding the situation of the day before. The family member stated that the resident's back hurts from recent surgery and it hurts when she is on the bedpan. He implied that the bedpan spilled because she may have moved around to get comfortable. The resident stated that the aides were wonderful to her, take good care of her, come in and ask her if she needs anything, and walk her to the toilet if she needs to go. According to nursing notes, the resident prefers to wear her own clothes to bed. The resident stated several times during the conversation that her care is wonderful. The Director of Nursing's note contained no information regarding the allegation that Resident 3 was left on the bedpan for an extended period of time. Interview with Registered Nurse 1 on March 6, 2020, at 1:24 p.m. revealed that she was notified by Nurse Aides 2 and 3 that Resident 3 was upset and crying, and when she entered the resident's room she noticed that the resident had the same clothes on that she had on the day before, because she had worked the day before. She noted that there was dried urine on the resident's bed sheets and when the nurse aides went to change the resident's bed linens they noted that she was still on the bed pan. She indicated that she had the nurse aides write statements. Interview with Nurse Aide 2 on March 6, 2020, at 1:30 p.m. revealed that she had just started her shift and went into Resident 3's room to perform a.m. care. The resident was crying and she tried to calm her down and told her she was going to clean her up like she always did. She went to take her to the bathroom and found that the resident was still on the bedpan. The resident could not recall how long she was on the bed pan. She told Registered Nurse 1 and she handled it from there. Interview with Nurse Aide 3 on March 6, 2020, at 1:35 p.m. revealed that she had just started her shift and was starting a.m. care for residents. Nurse Aide 2 was assigned to Resident 3 and had her come in to help with Resident 3. She noticed that the resident was crying and in pain from sitting on the bedpan. Interview with Resident Family Member 3 on March 9, 2020, at 12:37 p.m. revealed that he went to visit Resident 3 and when he got to the front desk, the nurse pulled him aside and said they were sorry, the resident was left on the bed pan for an extended period of time. They went back to the resident's room and she indicated that she was upset, but had calmed down now. He went to the Director of Nursing's office to inform her about the incident and she indicated that she was already aware and was doing an internal investigation. There was no documented evidence that Registered Nurse 1's allegation of neglect was reported to the Department of Health and to the Adult Protective Services agency. Interview with the Director of Nursing on March 9, 2020, at 3:00 p.m. revealed that she felt that there was no allegation of neglect after speaking with the resident and the resident's family. 28 Pa. Code 201.18(b)(1) Management. 28 Pa. Code 201.18(e)(1) Management.
F 0610 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Respond appropriately to all alleged violations.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of policies and clinical records, as well as staff interviews, it was determined that the facility failed to complete thorough investigations of incidents to rule out that neglect and/or abuse were involved for one of five residents reviewed (Resident 3). Findings include: The facility's policy regarding resident abuse, dated December 16, 2019, revealed that facility staff were to report any allegation or suspicion of abuse, neglect, exploitation, or the misappropriation of resident property immediately to their immediate supervisor, and all allegations of abuse, neglect, exploitation or mistreatment of [REDACTED]. An admission Minimum Data Set (MDS) assessments (a federally-mandated assessment of a resident's abilities and care needs) for Resident 3, dated February 8, 2020, revealed that the resident was understood, could understand, and required extensive assistance from staff for daily care tasks, including toileting. A nursing note for Resident 3, dated February 5, 2020, at 7:12 a.m., that was entered as incomplete documentation, revealed that the writer (Registered Nurse 1) was summoned by the nurse aides to the resident's room at approximately 6:45 a.m. The resident was found sitting in her bed in the same clothing she was wearing the day before, her clothing and bed linens were saturated with urine, and she was upset and crying. When the nurse aide staff rolled the resident to change her bedding, they found that the resident was sitting on a bed pan. The resident was not sure who placed her on the bed pan, but stated that she had been on it for quite some time, and she rang several times to be changed and use the bathroom, but no one came. The resident's skin on her buttocks was not broken or cut by the bedpan, but there was a very deep, prominent indentation in her skin, leaving an impression of the bedpan. A nursing note at 9:12 a.m. revealed that the resident's son came into the facility to visit and was informed of the morning's events involving the resident. A grievance/complaint form for Resident 3, dated February 6, 2020, referred to an attached note completed by the Director of Nursing. A nursing note, dated February 6, 2020, at 8:15 a.m. and completed by the Director of Nursing revealed that she spoke with the resident regarding it being reported that she was observed on the bedpan yesterday in the same clothes that she had on the day before, and that she was incontinent of urine while sitting on the bedpan. The Director of Nursing wrote that she had a conversation with the resident's other son yesterday and he stated that the resident's back hurts from recent surgery and it hurts when on the bedpan. He implied that the bedpan spilled because she may have moved around to get comfortable. The note indicated that the Director of Nursing spoke with the resident in the presence of her son and discussed the event. The resident stated that the aides are wonderful to her and take good care of her. The Director of nursing asked if they answer her call bell and she replied that she does not use her bell, but they come in and ask her if she needs anything and ask her if she needs to toilet, and if she does they walk her to the toilet, including during the night. It is noted in the electronic medical record that the resident was toileted at 1:05 a.m. and according to nursing notes the resident prefers to wear her own clothes to bed. The resident stated several times during the conversation that her care is wonderful. The investigation conclusion was that the resident has back pain from surgery and that the resident uses a bed pan. The resolution was that the resident was toileted per review of the medical record and prefers to wear clothes to bed. There was no documented evidence in the Director of Nursing's note to show that an investigation was completed related to the allegation that Resident 3 was left on the bedpan for an extended period of time. Interview with Registered Nurse 1 on March 6, 2020, at 1:24 p.m. revealed that she was notified by Nurse Aides 2 and 3 that Resident 3 was upset and crying, and when she entered the resident's room she noticed that the resident had the same clothes on that she had on the day before, because she had worked the day before. She noted that there was dried urine on the resident's bed sheets and when the nurse aides went to change the resident's bed linens they noted that she was still on the bed pan. She indicated that she had the nurse aides write statements. She was then off work for a couple of days and when she returned to work the Director of Nursing called her into her office and told her that she did not investigate the incident properly. The Director of nursing had Registered Nurse 1 strike out her note and indicate that it was incomplete documentation. The Director of Nursing wanted Registered Nurse 1 to write another progress note that matched what she had written, but she refused to do that. The Director of Nursing also threw away all the paperwork that she started regarding the incident. Interview with Nurse Aide 2 on March 6, 2020, at 1:30 p.m. revealed that she had just started her shift and went into Resident 3's room to perform a.m. care. The resident was crying and she tried to calm her down and told her she was going to clean her up like she always did. She went to take her to the bathroom and found that the resident was still on the bedpan. The resident could not recall how long she was on the bed pan. She told Registered Nurse 1 and she handled it from there and had Nurse Aide 2 complete a witness statement. Interview with Nurse Aide 3 on March 6, 2020, at 1:35 p.m. revealed that she had just started her shift and was starting a.m. care for residents. Nurse Aide 2 was assigned to Resident 3 and had her come in to help with Resident 3. She noticed that the resident was crying and in pain from sitting on the bedpan. Registered Nurse 1 had her complete a witness statement regarding the incident. Interview with Resident Family Member 3 on March 9, 2020, at 12:37 p.m. revealed that he went to visit Resident 3 and when he got to the front desk, the nurse pulled him aside and said they were sorry, the resident was left on the bed pan for an extended period of time. They went back to the resident's room and she indicated that she was upset, but had calmed down now. He went to the Director of Nursing's office to inform her about the incident and she indicated that she was already aware and was doing an internal investigation. There was no documented evidence that a thorough investigation into Resident 3 being left on the bedpan for an extended period of time was completed. There was no documented evidence that statements were obtained from the staff involved in Resident 3's care at the time of the incident on February 5, 2020, including from Nurse Aides 2 and 3. Upon interview with the Director of Nursing on March 6, 2020, at 3:39 p.m. she indicated that her investigation was what she wrote in her progress note on

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F 0610 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) February 6, 2020. She spoke with the resident and there were no problems, and she spoke with the resident's family and they were pleased with her findings. She also spoke with Registered Nurse 1 who wrote incorrect documentation so she had her strike out her progress note. The Director of Nursing could not produce the witness statements from Nurse Aides 2 and 3. 28 Pa. Code 201.18(e)(1) Management. 28 Pa. Code 211.12(d)(5) Nursing services.
F 0658 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure services provided by the nursing facility meet professional standards of quality.** Based on review of Pennsylvania's Nursing Practice Act, facility policies and clinical records, as well as staff interviews, it was determined that the facility failed to ensure that a professional (registered) nurse reassessed a resident after a change in condition for one of five residents reviewed (Resident 3). Findings include: The Pennsylvania Code, Title 49, Professional and Vocational Standards, State Board of Nursing 21.11 (a)(1)(2)(4) indicated that the registered nurse was responsible for assessing human responses and plans, implementing nursing care, analyzing/comparing data with the norm in determining care needs, and carrying out nursing care actions that promote, maintain and restore the well-being of individuals. The facility's policy regarding nursing documentation, dated December 16, 2019, revealed that nursing progress notes were to be documented for residents who were experiencing a change in condition, until the condition stabilized. A nursing note for Resident 3, dated February 6, 2020, at 2:01 p.m. revealed that the nurse was called into the resident's room by activities. The resident was sitting up in a wheelchair and was complaining of mid-sternal chest pain that was non-radiating. The physician was paged, and a nursing note at 2:08 p.m. indicated that the resident stated her pain was starting to ease up. There was no further documented evidence that a professional (registered) nurse reassessed Resident 3 until a nursing note dated February 7, 2020, at 9:23 a.m. revealed that the resident verbally denied any chest pain or discomfort at that time. Interview with the Director of Nursing on March 6, 2020, at 3:54 p.m. confirmed that there was no documented evidence that Resident 3's change in condition was reassessed by a professional (registered) nurse, continuing until the condition stabilized. 28 Pa. Code 211.12(d)(1)(5) Nursing services.
F 0842 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.** Based on review of facility policies and clinical records, as well as staff interviews, it was determined that the facility failed to maintain clinical records that were complete and accurately documented for one of five residents reviewed (Resident 3). Findings include: The facility's policy regarding nursing documentation, dated December 16, 2019, revealed that documentation was to be factual and the result of a direct interaction with, or direct observation of, the resident. Nursing progress notes were to be documented for residents who experienced an accident other than a fall or an injury, until the condition stabilized, and were to be documented for residents who were experiencing a change in condition until the condition stabilized. A nursing note for Resident 3, dated February 5, 2020, at 7:12 a.m., that was entered as incomplete documentation, revealed that the writer (Registered Nurse 1) was summoned by the nurse aides to the resident's room at approximately 6:45 a.m. The resident was found sitting in her bed in the same clothing she was wearing the day before, her clothing and bed linens were saturated with urine, and she was upset and crying. When the nurse aide staff rolled the resident to change her bedding, they found that the resident was sitting on a bed pan. The resident was not sure who placed her on the bed pan, but stated that she had been on it for quite some time, and she rang several times to be changed and use the bathroom, but no one came. The resident's skin on her buttocks was not broken or cut by the bedpan, but there was a very deep, prominent indentation in her skin, leaving an impression of the bedpan. A nursing note at 9:12 a.m. revealed that the resident's son came into the facility to visit and was informed of the morning's events involving the resident. A nursing note for Resident 3, dated February 6, 2020, at 8:15 a.m. and completed by the Director of Nursing, revealed that she spoke with the resident and the resident's family member regarding the situation of the day before. The family member stated that the resident's back hurts from recent surgery and it hurts when she is on the bedpan. He implied that the bedpan spilled because she may have moved around to get comfortable. The resident stated that the aides were wonderful to her, take good care of her, come in and ask her if she needs anything, and walk her to the toilet if she needs to go. According to nursing notes, the resident prefers to wear her own clothes to bed. The resident stated several times during the conversation that her care is wonderful. The Director of Nursing's note contained no information regarding the allegation that Resident 3 was left on the bedpan for an extended period of time. Upon interview with the Director of Nursing on March 6, 2020, at 3:39 p.m. she stated that she spoke with Registered Nurse 1 who wrote incorrect documentation, so she had her strike out her progress note. Interview with Registered Nurse 1 on March 6, 2020, at 1:24 p.m. revealed that she was notified by Nurse Aides 2 and 3 that Resident 3 was upset and crying, and when she entered the resident's room she noticed that the resident had the same clothes on that she had on the day before, because she had worked the day before. She noted that there was dried urine on the resident's bed sheets and when the nurse aides went to change the resident's bed linens they noted that she was still on the bed pan. She indicated that she had the nurse aides write statements. She was then off work for a couple of days and when she returned to work the Director of Nursing called her into her office and told her that she did not investigate the incident properly. The Director of Nursing had Registered Nurse 1 strike out her note and indicate that it was incomplete documentation. The Director of Nursing wanted Registered Nurse 1 to write another progress note that matched what she had written, but she refused to do that. The Director of Nursing also threw away all the paperwork that she started regarding the incident. Interview with Nurse Aide 2 on March 6, 2020, at 1:30 p.m. revealed that she had just started her shift and went into Resident 3's room to perform a.m. care. The resident was crying and she tried to calm her down and told her she was going to clean her up like she always did. She went to take her to the bathroom and found that the resident was still on the bedpan. The resident could not recall how long she was on the bed pan. She told Registered Nurse 1 and she handled it from there. Interview with Nurse Aide 3 on March 6, 2020, at 1:35 p.m. revealed that she had just started her shift and was starting a.m. care for residents. Nurse Aide 2 was assigned to Resident 3 and had her come in to help with Resident 3. She noticed that the resident was crying and in pain from sitting on the bedpan Interview with Resident Family Member 3 on March 9, 2020, at 12:37 p.m. revealed that he went to visit Resident 3 and when he got to the front desk, the nurse pulled him aside and said they were sorry, the resident was left on the bed pan for an extended period of time. They went back to the resident's room and she indicated that she was upset, but had calmed down now. He went to the Director of Nursing's office to inform her about the incident and she indicated that she was already aware and was doing an internal investigation. There was no evidence to indicate that Registered Nurse 1's progress note of February 5, 2020, at 7:12 a.m. was inaccurate or incomplete or that Registered Nurse 1 should have been instructed to strike the note from the Resident 3's clinical record. 28 Pa. Code 211.5(f) Clinical records.