STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395702	A. Building B. Wing	06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beacon Ridge	1515 Wayne Avenue Indiana, PA 15701

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. 46994 Based on clinical record reviews, observations, and staff interviews, it was determined that the facility failed to maintain the dignity of one of 33 residents reviewed (Resident 75) who had an indwelling urinary catheter. Findings include: An admission Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 75, dated May 2, 2024, indicated that the resident was cognitively impaired, required partial to maximum assist with personal hygiene care, and had diagnoses that included stroke. A care plan for Resident 75, dated May 31, 2024, revealed that the resident had a Foley catheter (partially flexible tube that collects urine from the bladder and leads to a drainage bag) and that care included keeping her urine drainage bag covered in order to promote dignity. Physician's orders for Resident 75, dated May 30, 2024, included an order for the resident to have a Foley catheter. Observations of Resident 75 on June 5, 2024, at 8:54 a.m. revealed the resident lying in bed with her Foley catheter drainage bag attached to the side of her bed visible from the hallway and not inside a privacy bag. Interview with Registered Nurse 1 on June 5, 2024, at 8:59 a.m. confirmed that Resident 75's urinary catheter drainage bag did not have a cover or privacy bag on it, and it should have. Interview with the Director of Nursing on June 5, 2024, at 12:26 p.m. confirmed that Resident 75 did not have a dignity bag on her Foley catheter drainage bag at the time of the observations, and she should have. 28 Pa. Code 201.29(c) Resident Rights.

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.

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

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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. 19102 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 clarify questionable physician's orders for one of 33 residents reviewed (Resident 5). 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 to collect complete and ongoing data to determine nursing care needs, analyze the health status of individuals and compare the data with the norm when determining nursing care needs, and carry out nursing care actions that promote, maintain and restore the well-being of individuals. An admission Minimum Data Set (MDS) assessment (a federally-mandated assessment of a resident's abilities and care needs) for Resident 5, dated May 7, 2024, indicated that the resident had moderate cognitive impairment, had pressure ulcers, and diagnoses that included a stroke. A care plan, dated April 30, 2024, revealed that Resident 5 was at risk for developing pressure ulcers, and treatments were to be administered as ordered. A wound note for Resident 5, dated May 3, 2024, revealed the resident had a pressure-induced deep tissue injury (injury below the skin) on the right heel that measured 5.0 x 5.0 x 0.1 centimeters (cm) with recommendations to apply skin prep (forms a protective barrier) to the area twice a day. Physician's orders for Resident 5, dated May 3, 2024, included orders to apply skin prep to the resident's right heel twice a day. However, the resident's Treatment Administration Record (TAR) for May 3, 2024, through May 31, 2024, revealed that skin prep was applied to the resident's left heel twice a day and not the right heel. There was no documented evidence that Resident 5's physician's order to apply skin prep to the resident's left heel was clarified with the physician due to the resident's deep tissue injury to the right heel. Interview with the Director of Nursing on June 5, 2024, at 12:25 p.m. confirmed that the treatment order to the left heel should have been clarified.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident’s preferences and goals. 19102 Based on review of policies and clinical records, as well as staff interviews, it was determined that the facility failed to provide nutritional supplements as ordered by the physician for one of 33 residents reviewed (Resident 1), failed to ensure that the hypoglycemic protocol was followed for two of 33 residents reviewed (Residents 3, 38), failed to ensure physician's orders for medications were followed for one of 33 residents reviewed (Resident 48); and failed to ensure that physician's orders for bowel protocols/medications were followed for two of 33 residents reviewed (Residents 7, 74). Findings include: A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 1, dated February 27, 2024 revealed that the resident was cognitively impaired and had the potential for decreased nutritional intake. Physician's orders, dated April 30, 2024, included orders for the resident to receive a four ounce Mighty Shake (nutritional supplement) with each meal. The resident's care plan, dated May 14, 2024, indicated that the resident had a recent decrease in appetite. Observations of Resident 1's lunch tray on June 4, 2024, a 12:35 p.m. and breakfast tray on June 5, 2024, at 8:35 a.m. revealed that there was no Mighty Shake on the tray. Interview with Nurse Aide 2 on June 5, 2024, at 8:37 a.m. confirmed that the electronic record shows the order for Mighty Shake supplements, and that Resident 1 previously received Mighty Shakes on her meal trays, but there was none today. Interview with the Nursing Home Administrator on June 5, 2024, at 9:00 a.m. confirmed that Resident 1 did not receive her supplemental nutrition in the form of a Mighty Shake as per physician order, and she should have. A significant change MDS assessment for Resident 3, dated May 16, 2024, revealed that the resident was understood and able to understand others, required partial to maximum assistance with personal hygiene care, and had diagnoses that included diabetes. Physician's orders for Resident 3, dated April 3, 2024, included an order for staff to follow hypoglycemic interventions that included to give the resident 15 grams of glucose (sugar) if their blood glucose level was less than 70 milligrams/deciliter (mg/dl) and to recheck their blood sugar in 15 minutes. Review of the Medication Administration Record (MAR) for Resident 3, dated May 2024 and June 2024, revealed that on May 7, 2024, at 6:34 a.m. the resident's blood sugar was 65 mg/dl; on May 8, 2024, at 6:06 a.m. the resident's blood sugar was 66 mg/dl; on May 26, 2024, at 6:30 a.m. the resident's blood sugar was 61 mg/dl; and on June 5, 2024, at 6:12 a.m. the resident's blood sugar was 62 mg/dl. There was no documented evidence that the 15 grams of glucose was administered to Resident 3 or that the resident's blood sugar was rechecked in 15 minutes on these identified dates and times. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview with the Director of Nursing on June 5, 2024, at 12:26 p.m. confirmed that Resident 3's physician's orders for hypoglycemia were not followed as ordered on the above-mentioned dates and times. An admission MDS assessment for Resident 38, dated May 23, 2024, revealed that the resident was cognitively intact, required set-up or clean-up assistance with personal hygiene, and had diagnoses that included diabetes. Physician's orders for Resident 38, dated May 17, 2024, included orders for the staff to follow hypoglycemic interventions that included to give the resident 15 grams of glucose (sugar) if their blood glucose level was less than 70 milligrams/deciliter (mg/dl) and to recheck their blood sugar in 15 minutes. Review of the MAR for Resident 38, dated May 2024, revealed that on May 27, 2024, at 9:00 p.m. the resident's blood sugar was 58 mg/dl, and on May 28, 2024, at 5:28 a.m. the resident's blood sugar was 68 mg/dl. There was no documented evidence that the 15 grams of glucose was administered to Resident 38 or that the resident's blood sugar was rechecked in 15 minutes on these identified dates and times. An interview with the Director of Nursing on June 5, 2024, at 12:25 p.m. confirmed that Resident 38's physician's orders for hypoglycemia were not followed as ordered on the above-mentioned dates and times. A quarterly MDS assessment for Resident 48, dated June 3, 2024, revealed that the resident was cognitively intact, was independent with personal hygiene, and had diagnoses that included diabetes. Physician's orders for Resident 48, dated January 31, 2024, included orders for the resident to receive 4 units of insulin lispro one time of day and 8 units of insulin lispro two times a day at mealtimes. Resident 48 was to receive only half the dose of insulin ordered if she only ate half of her meal and no insulin if she refused her meal. Review of meal intake records for Resident 48, dated March, April, and May 2024, revealed that on March 9, 2024, at 6:00 p.m. the resident ate 50 percent of her meal; on March 26, 2024, at 9:00 a.m. the resident ate 25 percent of her meal; on March 31, 2024, at 1:00 p.m. the resident ate 50 percent of her meal; on April 1, 2024, at 9:00 a.m. the resident ate 25 percent of her meal; on April 2, 2024, at 9:00 a.m. the resident ate zero percent of her meal; on April 4, 2024, at 1:00 p.m. the resident ate 50 percent of her meal; on April 6, 2024, at 1:00 p.m. the resident ate 50 percent of her meal; on April 12, 2024, at 9:00 a.m. the resident ate 50 percent of her meal; on April 16, 2024, at 6:00 p.m. the resident ate 25 percent of her meal; on April 20, 2024, at 1:00 p.m. the resident ate zero percent of her meal; on May 13, 2024, at 6:00 p.m. the resident ate 25 percent of her meal; on May 14, 2024, at 6:00 p.m. the resident ate 50 percent of her meal; on May 19, 2024, at 9:00 a.m. the resident ate 25 percent of her meal; on May 21, 2024, at 6:00 p.m. the resident ate 25 percent of her meal; and on May 23, 2024, at 6:00 p.m. the resident ate 25 percent of her meal. Review of the MARs for Resident 48, dated March, April, and May 2024, revealed that the resident was given the full dose of insulin on the above dates and times when she ate 50 percent or less of her meal. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with the Assistant Director of Nursing on June 6, 2024, at 12:35 p.m. confirmed that insulin orders were not followed as ordered for Resident 48 on the above-mentioned dates and times. A quarterly MDS assessment for Resident 7, dated April 15, 2024, revealed that the resident was cognitively impaired, was always incontinent of bowel movements, and had diagnoses that included a stroke. Physician's orders for Resident 7, dated December 14, 2022, included orders for the resident to receive two 8.6 milligrams (mg) tablets of Senna as needed for constipation if no bowel movement for two days, a 10 mg bisacodyl suppository rectally as needed if no bowel movement for three days, and Fleets enema to be given rectally as needed if no bowel movement for four days. The resident's care plan, dated November 9, 2022, indicated that the resident was at risk for constipation and the bowel protocol was to be followed. Review of Resident 7's bowel records for March, April, and May 2024, revealed that there was no documented evidence that the resident had a bowel movement from March 2 through 5, April 6 through 9, and May 20 through 23, 2024. Review of the March, April and May 2024 MARs for Resident 7 revealed that staff did not initiate or follow the bowel protocol as ordered by the physician. Interview with the Director of Nursing on June 5, 2024, at 2:56 p.m. confirmed that the physician's orders for bowel medications were not followed for Resident 7. An admission MDS assessment for Resident 74, dated April 11, 2024, revealed that the resident was cognitively intact, required set-up or clean-up assist with personal hygiene, was frequently incontinent of bowel, and had diagnoses that included a right hip fracture. Physician's orders for Resident 74, dated April 5, 2024, included an order to give one 8.6 mg tablet of Senna if the resident did not have a bowel movement in two days, a 10 mg Bisacodyl suppository if the resident did not have a bowel movement in three days, and a Fleets enema if the resident did not have a bowel movement in four days. Review of the bowel record for Resident 74, dated May 2024 and June 2024, revealed that the resident did not have a bowel movement on May 15 through May 17, 2024; May 27 through May 30, 2024; and June 1 through June 3, 2024. A review of the MAR and nursing notes for Resident 74, dated May 2024 and June 2024, revealed no documented evidence that the facility followed the bowel protocol as ordered. Interview with the Nursing Home Administrator on June 5, 2024, at 2:15 p.m. confirmed that the bowel protocol was not followed for Resident 74 on the above-mentioned dates. 28 Pa. Code 211.12(d)(3)(5) Nursing Services.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 19102 Based on clinical record reviews and staff interviews, it was determined that the facility failed to follow recommendations from a wound consultation for one of 33 residents reviewed (Resident 5). Findings include: An admission Minimum Data Set (MDS) assessment (a federally-mandated assessment of a resident's abilities and care needs) for Resident 5, dated May 7, 2024, indicated that the resident had moderate cognitive impairment, pressure ulcers, and diagnoses that included a stroke. A care plan, dated April 30, 2024, revealed that the resident was at risk for developing pressure ulcers, and treatments were to be administered as ordered. A wound note, dated May 24, 2024, revealed the resident had a Stage III pressure ulcer on the right gluteus (buttocks) that measured 5.0 x 5.0 x 0.1 centimeters (cm) with recommendations to apply Santyl (removes dead tissue) to the area twice a day. However, the resident's Treatment Administration Record (TAR), dated May 2024, revealed that there was no documented evidence that Santyl was applied to the resident's right gluteus twice a day as recommended by the wound clinic on May 24, 2024. Interview with the Director of Nursing on June 5, 2024, at 12:25 p.m. confirmed that the recommendation to the right buttocks was not followed. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing Services.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 31760 Based on review of policies, clinical records, and investigation documents, as well as observations and staff interviews, it was determined that the facility failed to provide an environment that was free of accident hazards by failing to follow physician's orders and care-planned interventions for diets for one of 33 residents reviewed (Resident 29), failed to ensure that care-planned interventions were in place at the time of a fall for one of 33 residents reviewed (Resident 26), failed to follow physician's orders and care-planned interventions to prevent skin breakdown for one of 33 resident's reviewed (Resident 42), and failed to ensure that safe wheelchair transport techniques were used for one of 33 residents reviewed (Resident 79). Findings Include: An annual Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 26, dated May 9, 2024, revealed that the resident was cognitively impaired, was dependent on staff for personal care needs, had diagnosis that included Alzheimer's disease, and had a history of falls. A care plan for Resident 26, dated January 10, 2019, indicated that the resident was a high risk for falls and included an intervention, dated March 3, 2023, that the resident wear shoes when out of bed. Review of a fall investigation for Resident 26, dated October 20, 2023, at 7:30 p.m., included a witness statement by Nurse Aide 3 indicating that he had witnessed the resident fall from her chair and that Resident 26 was wearing yellow grip socks at the time of the fall. Interview with Assistant Director of Nursing on June 6, 2024, at 12:35 p.m. confirmed that Resident 26 was wearing slipper socks at the time of her fall from a chair on October 20, 2023, and she should have been wearing shoes per her care plan. A quarterly MDS assessment for Resident 29, dated February 20, 2024, revealed that the resident was understood, could understand others, and had a diagnosis which included Cerebral Vascular Accident (CVA - commonly known as a stroke) with hemiplegia (paralysis on one side of the body). A care plan for the resident, dated September 7, 2022, revealed that the resident had a self-care performance deficit related to a left hemiplegia and was able to feed herself after set up. A care plan, dated September 8, 2018, revealed that the resident had a potential nutritional problem related to CVA and dysphagia (a medical term for difficulty swallowing). Staff was to provide and serve the resident's diet as ordered. The resident was to receive a regular, mechanical soft/chopped diet (foods that can be successfully and safely swallowed), and regular liquids. Physician's orders for Resident 29, dated November 27, 2023, included an order for the resident to receive a regular, mechanical soft/chopped texture, regular consistency diet. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A nursing note for Resident 29, dated February 21, 2024, at 12:47 p.m. revealed that the resident expressed having something in her throat at lunch time. The resident was unsure of what food it was. Staff assisted the resident to clear her throat. The resident was able to breathe without difficulty, the writer provided the resident with fluids, and after several sips the resident was able to cough up the food. The resident coughed up a whole, fully intact chicken nugget. Speech therapy and the supervisor were notified. The resident was to have chopped meat. Education was provided to the floor and kitchen staff. Interview with the Director of Nursing on June 4, 2024, at 12:20 p.m. confirmed that Resident 29 was not served her lunch meal as ordered on February 21, 2024. A quarterly Minimum Data Set (MDS) assessment (a mandatory assessment of a resident's abilities and care needs) for Resident 42, dated March 5, 2024, revealed that the resident was cognitively impaired, had weekly skin checks, and required assistance for daily care tasks. The resident's care plan, dated December 13, 2023, revealed that she has frail/thin skin with decreased functional ability. Physician's orders, dated December 25, 2023, included an order for the resident to wear bilateral (both) upper extremity Geri sleeves (a protective arm sleeve that assists in the prevention of skin tears) and to remove them for care and reapply. Observations on June 5, 2024, at 1:00 p.m. and 1:50 p.m. revealed that Resident 42 was sitting in the dining area and her room, respectively, and did not have her bilateral Geri sleeves on her arms. Interviews with Nurse Aides 2 and 4 on June 5, 2024, at 1:50 p.m. revealed that the resident's daughter prefers the resident to wear long sleeves and a sweater. They preceded to look for the Geri sleeves and found one in the resident's drawer and placed it on her but did not find the second one in her room. The resident is not care planed to use sweaters and long sleeves instead of the Geri sleeves. Interview with Registered Nurse 1 on June 5, 2024 at 2:04 p.m. confirmed that Resident 42 was ordered bilateral Geri sleeves and they should be on her arms. Interview with the Director of Nursing on June 5, 2024, at 2:15 p.m. confirmed that Resident 42 has frail skin and a physcian order to wear bilateral upper extremity Geri sleeves, and they were not on the resident and should have been. An admission Minimum Data Set (MDS) assessment (a mandatory assessment of a resident's abilities and care needs) for Resident 79, dated May 29, 2024, revealed that the resident was minimally cognitively impaired and required assistance for daily care tasks and transport. The resident's care plan, dated May 24, 2024, revealed that he was at risk for falls. Observations on June 4, 2024, at 10:20 a.m. revealed that Resident 79 was being pushed through the hallway in a wheelchair by Nurse Aide 4 and the wheelchair leg rests were in place and down. The resident had socks on his feet, but his feet were between the footrests dangling less than one inch above the floor. Interview with Nurse Aide 4, at that time, indicated that she knew his footrests were in place but did not realize he did not have his feet resting on them. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	There was no documented evidence that Resident 79 was assessed as being safe to hold his feet up while being transported in a wheelchair. Interview with the Nursing Home Administrator on June 4, 2024, at 1:10 p.m. confirmed that Resident 79 has a history of falls and that his feet should have been resting on the footrests during transport, and they were not. 28 Pa. Code 201.14(a) Responsibility of Licensee. 28 Pa. Code 201.18(b)(1)(e)(1) Management. 28 Pa. Code 211.12(d)(1)(5) Nursing Services.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 19102 Based on review of policies and clinical records, as well as observations and staff interviews, it was determined that the facility failed to ensure that interventions were in place to prevent urinary tract infections for one of 33 residents reviewed (Resident 5) who had an indwelling urinary catheter. Findings include: The facility's policy regarding urinary catheter care, dated January 16, 2024, indicated that the catheter tubing and drainage bag were to be kept off the floor. An admission Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 5, dated May 7, 2024, revealed that the resident had moderate cognitive impairment, had an indwelling urinary catheter (a tube inserted and held in the bladder to drain urine), and had diagnoses that included neurogenic bladder (bladder dysfunction caused by nervous system conditions). Physician's orders, dated April 29, 2024, included an order for the resident to have an indwelling urinary catheter. Observations of Resident 5 on June 5, 2024, at 9:13 a.m. revealed that the resident was in bed, and the catheter tubing was positioned under a fall mat that was on the floor beside her bed and in contact with the floor. Interview with Nurse Aide 5 on June 5, 2024, at 9:17 a.m. confirmed that Resident 5's catheter tubing was on the floor under the fall mat and it should not have been. Interview with the Director of Nursing on June 5, 2024, at 12:25 p.m. confirmed that Resident 5's catheter tubing should not be on the floor. 28 Pa. Code 211.12(d)(1)(5) Nursing Services.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 41233 Based on review of policies and clinical records, as well as observations and staff interviews, it was determined that the facility failed to ensure that oxygen tubing and a nasal canula remained off the floor for one of 33 residents reviewed (Resident 42). The facility's policy regarding oxygen therapy, dated January 16, 2024, indicated that oxygen was to be administered safely and in accordance with physician's orders. A quarterly Minimum data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 42, dated March 5, 2024, revealed that the resident was cognitively impaired and had diagnoses that included chronic respiratory failure with hypoxia (a serious condition that causes low blood oxygen) and a history of generalized anxiety. A care plan, dated August 29, 2023, indicated that Resident 42 was to receive continuous oxygen while sleeping due to a respiratory disease. Physician's orders for Resident 42, dated April 11, 2024, included an order for the resident to receive continuous oxygen at a flow rate of 2 liters per minute via nasal cannula (a tube that delivers oxygen into the nostrils) while sleeping. Observations of Resident 42 awake in her room on June 5, 2024, at 1:38 p.m. revealed that her oxygen tubing and nasal canula were curled up on the floor beside the oxygen concentrator (an oxygen delivery device) with the tubing and nasal cannula in contact with the floor. Interview with Nurse Aide 2 on June 5, 2024, at 1:40 p.m. confirmed that Resident 42 wears her oxygen while sleeping and that the oxygen tubing and nasal canula should not be in contact with the floor. Interview with the Director of Nursing on June 5, 2024, at 2:18 p.m. confirmed that Resident 42's oxygen tubing and nasal canula should not be in contact with the floor. 28 Pa. Code 211.12(d)(3)(5) Nursing Services.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 19102 Based on review of policies and clinical records, as well as staff interviews, it was determined that the facility failed to maintain a complete and accurate accounting of controlled medications (medications with the potential to be abused) for two of 33 residents reviewed (Residents 7, 58). Findings include: The facility's policy regarding controlled substances, dated January 16, 2024, indicated that each controlled substance prescription is documented in the resident's medical record with the date, time and signature of the person administering the prescription. The prescription is recorded in the patient's health record and recorded on the Medication Administration Record (MARs). A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 7, dated April 15, 2024, indicated that the resident was cognitively impaired, had pain occasionally, received pain medication routinely and as needed, received an opioid (a controlled pain medication). Physician's orders for Resident 7, dated January 9, 2023, included an order for the resident to receive 5 milligrams (mg) of Oxycodone (a narcotic pain medication) twice a day as needed for buttock pain related to pressure areas for a pain scale of 4-10 (on a scale of 1 to 10, where 10 is the worst pain). Resident 7's controlled drug records for March 2024 indicated that a dose of Oxycodone was signed-out for administration on March 22, 2024, at 7:30 p.m. and March 31, 2024, at 9:00 p.m. However, the resident's clinical record, including the MAR, contained no documented evidence that the sign-out doses of Oxycodone were actually administered to the resident on those dates/times. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 58, dated March 22, 2024, indicated that the resident was cognitively intact and had diagnoses that included anxiety. Physician's orders for Resident 58, dated March 18, 2024, included an order for the resident to receive one 0. 5 mg tablet of Lorazepam (a controlled medication used to treat anxiety) every 12 hours as needed for anxiousness/restlessness related to anxiety. Resident 58's controlled drug records for April and May 2024 indicated that a dose of Lorazepam was signed-out for administration on April 17, 2024, at 9:00 p.m.; April 19, 2024, at 9:00 a.m.; April 30, 2024, at 9:00 p.m.; May 1, 2024, at 9:00 p.m.; May 2, 2024, at 11:00 p.m.; May 20, 2024, at 9:00 p.m.; and May 30, 2024, at 9:00 p.m. However, the resident's clinical record, including the MAR, contained no documented evidence that the sign-out doses of Lorazepam were actually administered to the resident on those dates/times. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with the Assistant Director of Nursing on June 6, 2024, at 12:35 p.m. confirmed that there was no documented evidence that the doses of Oxycodone and Lorazepam that were signed-out by nurses were actually administered to Residents 7 and 58 on the above dates/times. 28 Pa. Code 211.12(d)(1)(5) Nursing Services.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 31760 Based on review of clinical records, as well as staff interviews, it was determined that the facility failed to ensure that non-pharmacological (non-medication) interventions were attempted prior to the administration of anti-anxiety medications for one of 33 residents reviewed (Resident 58). Findings include: A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 58, dated March 22, 2024, indicated that the resident was cognitively intact and had diagnoses that included anxiety. A care plan for the resident, dated November 9, 2021, revealed that the resident was at risk for mood decline/anxiety. If the resident had any signs/symptoms of anxiety, staff was to attempt to identify the source and eliminate it if possible. Staff will allow the resident to express feelings/concerns. Staff will offer emotional support and empathetic listening as needed. De-escalation preferences included music, books, TV, and friends. If the resident was restless, staff will check on the resident's needs (pain, hunger, thirst, toilet, etc.). Physician's orders for Resident 58, dated March 18, 2024, included an order for the resident to receive one 0. 5 mg tablet of Lorazepam (a medication used to treat anxiety) every 12 hours as needed for anxiousness/restlessness related to anxiety. Resident 58's Medication Administration Records (MARs) for April and May 2024 revealed that staff administered the one 0.5 mg tablet of Lorazepam for anxiousness/restlessness on April 8, 2024, at 8:29 a.m. ; April 18, 2024, at 8:29 p.m.; April 26, 2024, at 9:59 p.m.; April 27, 2024, at 9:37 p.m.; April 28, 2024, at 9:27 p.m.; May 2, 2024, at 9:08 p.m.; May 5, 2024, at 8:08 p.m.; May 6, 2024, at 9:00 p.m.; May 9, 2024, at 8:22 p. m.; May 10, 2024, at 9:18 p.m.; May 13, 2024, at 8:55 p.m.; May 24, 2024, at 9:00 p.m.; May 25, 2024, at 9:00 p.m.; May 26, 2024, at 9:21 p.m.; May 27, 2024, at 9:21 p.m.; May 28, 2024, at 9:00 p.m.; and May 29, 2024, at 9:07 p.m. There was no documented evidence that non-medication interventions were attempted prior to the administration of Lorazepam. Interview with the Assistant Director of Nursing on June 5, 2024, at 12:20 p.m. confirmed that there was no documented evidence that staff attempted non-medication interventions prior to administering the as needed Lorazepam to Resident 58 on the above-mentioned dates and times. 28 Pa. Code 211.12(d)(5) Nursing Services.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41233 Based on review of facility policies, as well as observations and staff interviews, it was determined that the facility failed to properly date medications after they were opened in two of three medication rooms reviewed (Landings and Bayside), and failed to discard expired medical supplies. Findings include: The facility's policy regarding medication storage and disposal, dated [DATE], revealed that the facility would properly date medication vials after they were opened and remove outdated supplies from the facility inventory. Observations in the Landing medication room refrigerator on [DATE], at 12:12 p.m. revealed that there was one 30 ml (milliliter) bottle of Ativan opened and undated. Interview with Licensed Practical Nurse 6 on [DATE], at 12:18 p.m. confirmed that the Ativan was open and should have been labeled with the date it was opened. Observations in the Bayside medication room refrigerator on [DATE], at 12:24 p.m. revealed that there was one opened and undated multi-dose vial of insulin Glargine (a type of long acting insulin). There was also 43 blue-top and 63 pink-top blood collection tubes that expired February 29, 2024, and [DATE], respectively. Interview with Registered Nurse 7 on [DATE], at 12:42 p.m. confirmed that the opened insulin vial should have been dated, and the expired blood collection tubes should have been discarded. Interview with the Nursing Home Administrator on [DATE], at at 2:20 p.m. confirmed that the opened vials of insulin and Ativan should have been dated upon opening, and the blood collection tubes were expired and should have been discarded. 28 Pa. Code 211.9(a)(1) Pharmacy Services.

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F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results. 31760 Based on review of facility policies and clinical records, as well as staff interviews, it was determined that the facility failed to obtain a physician's order for an invasive procedure to collect a specimen for a laboratory test for one of 33 residents reviewed (Resident 58). Findings include: The facility's policy regarding intermittent catheterization (the insertion and removal of a catheter several times a day to empty the bladder), dated January 16, 2024, indicated that staff was to verify that there is a physician's order for this procedure. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 58, dated December 25, 2024, revealed that the resident was usually understood and could usually understand others. A care plan for the resident, dated September 23, 2021, indicated that the resident had a potential for discomfort due to urinary retention (when the bladder does not empty completely or at all). Staff was to perform intermittent catheterization as ordered by the physician and as needed. Physician's orders for Resident 58, dated December 19, 2023, included an order for staff to obtain a Urine Flex (the laboratory first performs a chemical urine test to detect abnormalities such as blood, protein, glucose, and indirect indicators of bacterial infection) for nausea/vomiting and elevated temperature. A nursing note for Resident 58, dated December 19, 2023, at 11:14 a.m. revealed that the writer attempted to straight cath (an invasive procedure in which a plastic tube is inserted into the bladder) the resident this a. m. and was unable to obtain urine at that time. A nursing note at 11:09 p.m. revealed that urine was obtained from the resident via female cath for the Urine Flex as ordered. A nursing note for Resident 58, dated April 8, 2024, at 5:58 a.m. revealed that the writer attempted to obtain urine via straight cath for the resident's yearly urine micro albumin (checks for small amounts of albumin in the urine which could be the first sign of kidney disease) times two attempts. They were unable to obtain enough urine for the lab to test to be completed. Interview with the Assistant Director of Nursing on June 5, 2024, at 12:20 p.m. confirmed that there was no evidence that a physician's order was obtained for Resident 58 to be catheterized to obtain the urine specimens on the above dates. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing Services.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. 31760 Based on review of clinical records and investigation documents, as well as staff interviews, it was determined that the facility failed to ensure that residents were provided the proper food consistency as ordered by the physician for one of 33 residents reviewed (Resident 29). This deficiency was cited as past non-compliance. Findings include: A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 29, dated February 20, 2024, revealed that the resident was understood, could understand others, and had a diagnosis which included Cerebral Vascular Accident (CVA - commonly known as a stroke) with hemiplegia (paralysis on one side of the body). A care plan for the resident, dated September 7, 2022, revealed that the resident had an Activities of Daily Living (ADL) self-care performance deficit related to a left hemiplegia, and that the resident was able to feed herself after set up. A care plan, dated September 8, 2018, revealed that the resident had a potential nutritional problem related to CVA and dysphagia (a medical term for difficulty swallowing). Staff were to provide and serve the resident's diet as ordered. The resident was to receive a regular, mechanical soft/chopped diet (provides foods provide foods that can be successfully and safely swallowed) and regular liquids. Physician's orders for Resident 29, dated November 27, 2023, included an order for the resident to receive a regular, mechanical soft/chopped texture, regular consistency diet. A nursing note for Resident 29, dated February 21, 2024, at 12:47 p.m. revealed that the resident expressed having something in her throat at lunch time. The resident was unsure of what food it was. Staff assisted the resident to clear her throat. The resident was able to breathe without difficulty, the writer provided the resident with fluids, and after several sips the resident was able to cough up the food. The resident coughed up a full/intact chicken nugget. Speech therapy and the supervisor were notified. The resident's diet was to have her meat chopped. Education was provided to the floor and kitchen staff. Interview with the Director of Nursing on June 4, 2024, at 12:20 p.m. confirmed that Resident 29 was not served her lunch meal as ordered on February 21, 2024. Following the incident with Resident 29 on February 21, 2024, the facility's corrective actions included: Nursing staff were educated on the need for importance of following the correct diet order/texture as well as reading the tray card tickets for accuracy. All dietary staff were educated on the importance of following the correct diet order/texture as well as reading the tray card tickets for accuracy. All involved staff were written up for providing and serving the incorrect diet texture. (continued on next page)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Tray accuracy audit tools are in place and will be completed accordingly. It will be available for the manager in charge of the dining room to complete. The dietary team will complete randomized tray accuracy audits to ensure proper accuracy for the next 10 days. The dietary team will then review results and tamper down if appropriate. Meal ticket/diet check accuracy process: The cook reads the meal ticket and plates the food based on what they chose, as well as the diet and texture that is ordered. Then the first dietary aide receives the meal ticket, as well as the plate of food to put on the tray along with the dessert. The tray is then sent down the line to add beverages as well as condiments if needed then placed in the delivery cart then delivered to the floors for the tray pass. An audit of resident diets was completed. A review of the facility's corrective actions revealed that they were in compliance with F805 on February 21, 2024. 28 Pa. Code 211.12(d)(3)(5) Nursing Services.

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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. 31760 Based on review of facility policies, as well as observations and staff interviews, it was determined that the facility failed to store and prepare food in accordance with professional standards for food service safety by failing to store food under sanitary conditions, failing to ensure that a microwave used to reheat resident food was clean (Bayside Nourishment Center), and failing to ensure that ice was made and stored in sanitary ice machines for one of two ice machines (Bayside Nourishment Center). Findings include: The facility's policy regarding food and supply storage, dated January 16, 2024, revealed that most, but not all, products contain an expiration date. The words sell-by, best-by, enjoy-by, or use-by should precede the date. The sell-by date is the last date that food can be sold or consumed; do not sell products in retail areas or place them on patient trays/resident plates past the date on the product. Foods past the use-by, sell-by, best-by, or enjoy by date should be discarded. Cover, label, and date unused portions and open packages. Products are good through the close of business on the date notes on the label. Date and rotate items: first in, first out (FIFO). Discard food past the use-by or expiration date. The facility's policy regarding thawing frozen meat/poultry/seafood, dated January 16, 2024, indicated to count the day the raw meat was removed from the freezer as day one; it must be cooked by the end of +4 days. Label with the date it was removed from the freezer and date by which it must be used by. Add a yellow dot to the orange label to indicate a product that is thawing. If the package leaks as it thaws, the meat poultry must be used as soon as it thaws (usually +2 days). Observations in the main kitchen of the walk-in freezer on June 3, 2024, at 9:21 a.m. revealed that there was a clear plastic bag that contained Danishes that was out of the original packaging carton that was not dated with the date that they were opened and/or a use by date. There was a clear plastic bag that contained dinner rolls that was out of the original packaging carton that was not dated with the date that they were opened and/or a use by date. Interview with the [NAME] Manager at the time of observation confirmed that the Danishes and dinner rolls should have been dated with the date that they were opened and a use by date. Observations in the main kitchen of the walk-in cooler on June 3, 2024, at 9:24 a.m. revealed that on the bottom shelf there was a metal pan that contained a five-pound roll of ground hamburger that had a red juice in the bottom of the metal pan. There was a date of May 28, 2024, on the package. However, there was no date when the ground meat was removed from the freezer to be thawed, and there was no date as to when the ground meat was to be cooked by. Interview with the [NAME] Manager at the time of observation revealed that the date on the package was the date that they took the ground meat from the freezer to be thawed. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview with the Regional Dietary Manager on June 3, 2024, at 1:04 p.m. confirmed that staff should have placed an orange sticker on the pan that had the ground meat thawing to indicate the date when the product was removed from the freezer to be thawed and should also have a date when it was to be cooked by. Observations of the microwave used to reheat resident food in the Bayside Nourishment Center June 6, 2024, at 8:57 a.m. revealed that there was food splattered on the inside of the door, all three inside walls, the top inside wall, and on the plate and bottom wall. Interview with the Staff Development/Registered Nurse at the time of the observation confirmed that the microwave needed to be cleaned. Observations of the ice machine in the Bayside Nourishment Center on June 6, 2024, at 9:03 a.m. revealed that the drainpipe coming from the ice machine extended down into and past the rim of a funnel-shaped pipe that extended up from the floor drain. There was no air gap between the end of the ice machine's drain pipe and the floor drain. Interview with the Director of Maintenance on June 6, 2024, at 2:53 p.m. confirmed that the ice machine in the Bayside Nourishment Center did not have an air gap between the drain pipe and the floor drain for back-flow prevention. 28 Pa. Code 211.6(f) Dietary Services.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 19102 Based on review of the facility's plans of correction for previous surveys, and the results of the current survey, it was determined that the facility's Quality Assurance Performance Improvement (QAPI) committee failed to maintain compliance with nursing home regulations and ensure that plans to improve the delivery of care and services effectively addressed recurring deficiencies. Findings include: The facility's deficiencies and plans of correction for State Survey and Certification (Department of Health) survey ending July 27, 2023, revealed that the facility developed plans of correction that included quality assurance systems with audits to ensure that the facility maintained compliance with cited nursing home regulations. The results of the audits were to be reported to the QAPI committee for review. The results of the current survey, ending June 6, 2024, identified repeated deficiencies regarding professional standards being met, quality of care, that the resident's environment was free of accident hazards, urinary catheter care, issues with oxygen therapy, preventing issues with the accountability of controlled medications (drugs with the potential to be abused), ensuring that food was properly stored, and following infection control practices. The facility's plan of correction for a deficiency regarding a failure to clarify physician's orders, cited during the survey ending July 27, 2023, revealed that the facility developed a plan of correction that included completing audits and reporting the results of the audits to the QAPI committee for review. The results of the current survey, cited under F658, revealed that the facility's QAPI committee failed to successfully implement their plans to ensure ongoing compliance with regulations regarding the clarification of physician's orders. The facility's plan of correction for a deficiency regarding quality of care, cited during the survey ending July 27, 2023, revealed that the facility developed a plan of correction that included completing audits and reporting the results of the audits to the QAPI committee for review. The results of the current survey, cited under F684, revealed that the facility's QAPI committee failed to successfully implement their plan to ensure ongoing compliance with regulations regarding quality of care. The facility's plans of correction for deficiencies regarding ensuring that the resident environment was free of accident hazards, cited during the survey ending on July 27, 2023, revealed that audits would be conducted and the results of the audits would be brought before the QAPI committee for further monitoring. The results of the current survey, cited under F689, revealed that the QAPI committee was ineffective in maintaining compliance with the regulation regarding ensuring that the environment was free of accident hazards. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility's plan of correction for a deficiency regarding a failure to provide proper incontinent and catheter care and/or toileting, cited during the survey ending July 27, 2023, revealed that the facility would complete audits and the results would be reviewed as part of quality assurance. The results of the current survey, cited under F690, revealed that the facility's QAPI committee was ineffective in maintaining compliance with the regulation regarding incontinent/catheter care and/or toileting. The facility's plan of correction for a deficiency regarding a failure to provide oxygen therapy as ordered by the physician, cited during the survey ending July 27, 2023, revealed that the facility would complete audits and the results would be reviewed as part of quality assurance. The results of the current survey, cited under F695, revealed that the facility's QAPI committee was ineffective in maintaining compliance with the regulation regarding providing oxygen therapy as ordered by the physician. The facility's plan of correction for a deficiency regarding the failure to account for controlled medications, cited during the survey ending July 27, 2023, revealed that the facility would complete audits and the results would be reviewed as part of quality assurance. The results of the current survey, cited under F755, revealed that the facility's QAPI committee was ineffective in correcting deficient practices related to the accountability of controlled medications. The facility's plan of correction for a deficiency regarding appropriate food storage cited during the survey ending July 27, 2023, revealed that the facility would complete audits and the results would be reviewed as part of quality assurance. The results of the current survey, cited under F812, revealed that the facility's QAPI committee was ineffective in maintaining compliance with the regulation regarding food storage. The facility's plans of correction for deficiencies regarding infection control practices, cited during the survey ending July 27, 2023, revealed that the facility would complete audits and report the results of the audits to the QAPI committee for review. The results of the current survey, cited under F880, revealed that the facility's QAPI committee failed to successfully implement their plan to ensure ongoing compliance with regulations regarding infection control practices. Refer to F658, F684, F689, F690, F695, F755, F812, F880. 28 Pa. Code 201.14(a) Responsibility of Licensee. 28 Pa. Code 201.18(e)(1) Management.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395702	A. Building B. Wing	06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beacon Ridge	1515 Wayne Avenue Indiana, PA 15701

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 41233 Based on review of policies and clinical records, as well as observations and staff interviews, it was determined that the facility failed to ensure that proper infection control practices were followed during wound care for two of 33 residents reviewed (Residents 45, 59). Findings include: The facility's policy regarding hand hygiene, dated January 16, 2024, indicated that hand hygiene is an important infection control measure to prevent illness in skilled nursing homes, and that hands should be sanitized or washed before and after the use of gloves. An admission Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 59, dated April 21, 2024, revealed that the resident was moderately cognitively impaired, had diagnoses that included peripheral vascular disease (a circulatory condition that reduces blood flow to the limbs). Physician's orders, dated May 24, 2024, included an order to cleanse the left foot with normal saline solution, pat dry, apply betadine, a heel cushion and soft rolled gauze wrap. Observations on June 4, 2024, at 2:05 p.m. revealed that Licensed Practical Nurse 8 removed Resident 59's right and left foot dressing; removed her gloves, and without performing hand washing or sanitizing her hands; donned new gloves; cleansed the left foot with normal saline solution, patted it dry, applied betadine, a heel cushion and soft rolled gauze wrap; and then removed her gloves, and without performing hand washing or sanitizing her hands, donned new gloves. Licensed Practical Nurse 8, then cleansed the right foot with normal saline solution; patted it dry; applied betadine, a heel cushion and a soft rolled gauze wrap; removed her gloves; and washed her hands. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 45, dated May 20, 2024, revealed that the resident was severely cognitively impaired and had diagnoses that included peripheral vascular disease. Physician's orders, dated May 24, 2024, included an order to cleanse the third digit of the right foot with normal saline solution, pat dry, apply medihoney (a healing cream) and a calcium alginate dressing (specialty dressing used for high drainage) to the wound. Observations on June 4, 2024, at 2:41 p.m. revealed that Licensed Practical Nurse 8 cleansed Resident 45's wound on the third digit of his right foot with normal saline solution, patted it dry, applied medihoney and a calcium alginate dressing to the wound base, removed her gloves to begin care on a second wound, and donned new gloves without performing hand washing or sanitizing her hands. Interview with Licensed Practical Nurse 8 on June 4, 2024, at 3:10 p.m. confirmed that while performing wound care on Resident 45 and 59, she did not perform hand hygiene after removing her gloves and donning new gloves. Interview with the Director of Nursing on June 4, 2024, at 3:18 p.m. confirmed that Licensed Practical Nurse 8 should have washed her hands or sanitized them after removing her gloves and before donning new gloves, and she did not. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395702	A. Building B. Wing	06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beacon Ridge	1515 Wayne Avenue Indiana, PA 15701

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	28 Pa. Code 211.12(d)(1)(5) Nursing Services.