STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395434	A. Building B. Wing	07/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MT Lebanon Rehabilitation and Wellness Center	350 Old Gilkeson Road Pittsburgh, PA 15228

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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32773 Based on review of facility policies and clinical records, staff interviews and written statements, it was determined that the facility failed to ensure that a resident was free from neglect by failing to provide adequate supervision of a two person transfer to prevent an avoidable accident which resulted in actual harm of a resident causing a left intertrochanteric femur fracture (breaking of the upper part of the leg bone between the bony prominence near to the hip muscles attachments) for one of eight residents (Resident R58). Findings include: Review of the facility policy Abuse Protection last reviewed 3/22/22, indicated that neglect is defined as the failure to provide the goods and services necessary to avoid physical harm, mental anguish or mental illness. Neglect refers to failure through inattentiveness, carelessness, or omission to provide timely, consistent, safety adequate, and appropriate services, treatment of care, including but not limited to nutrition, medication, therapies, and activities of daily living. Review of Resident R58's Minimum Data Set (MDS - periodic review of care needs) dated 5/20/22, indicated she was admitted to the facility on [DATE], Section C Cognitive Patterns, Brief Interview for Mental Status (test of cognitive status) score is 15 (cognitively intact), and her current diagnosis included high blood pressure, diabetes, and left femur fracture. Review of Resident R58's MDS dated [DATE], Section G - Functional Status, Questions G0110b, ADL (activities of daily living) Assistance for Transfer Status, indicated she required an extensive assistance of two or more staff members when transferring from one surface to another. Review of a physician order dated 3/24/22, instructed staff to transfer resident with a sit to stand (a type of mechanical lift) and assist times 2 staff. Review of facility employee witness statement dated 3/27/22, not timed, completed by Nurse Aide (NA) Employee E1 indicated that on 3/26/22, when transferring Resident R58, from her chair with the sit to stand. I noticed her head fall to the right and her body start go limp. We (the roommate's daughter) lowered her to the floor. I called the nurse. She came in and Resident R58 was not responding. After a few times of calling her name, she said she wanted to get up she said her leg was feeling pain, and we covered her up, and sent her to the hospital emergency room . (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0600 Level of Harm - Actual harm Residents Affected - Few	Review of facility Witness Statement dated 3/26/22, at 4:30 p.m. completed by Registered Nurse (RN) Employee E2, indicated she was alerted to Resident R58's room by NA Employee E1. Upon entering the room, resident was laying on her back in the supine position (laying on back face up). Resident did respond when her name was called upon assessment the resident began to scream my leg, my leg while guarding her left leg. As staff began to elevate head because she complained of I can't breathe, she yelled louder in extreme pain. This staff instructed staff to keep her as she was lying, not to attempt to move her in anyway, while this nurse called for a transfer to the hospital. That NA Employee E1 stated resident loss consciousness and began to slide out of lift. During a phone interview on 7/13/22, at 3:15 p.m. NA Employee E1 stated on 3/26/22, she was transferring Resident R58 from her wheelchair to her bed by herself, NA Employee E1 stated that she knew Resident R58 should have had two staff to assist her with the transfer and did the transfer by herself, that the resident passed out on the lift, and the roommates daughter helped her lower the resident to the floor. During an interview on 7/13/22, at 3:24 p.m. Resident R58 stated she broke her hip in March of 2022, that it hurt at the time, and she cannot remember the incident. During an interview on 7/14/22, at 11:30 a.m. that on 3/26/22, RN Employee E2 stated that she heard NA Employee E1 yelling and that she went into the room and Resident R58 was lying on the floor, that during her assessment resident screamed out in pain, and was guarding her leg, which was rotated out, and the resident could not move it. That Resident R58 was ordered a sit to stand with an assist of two staff, and NA Employee E1 moved her by herself. During a phone interview on 7/15/22, at 9:51 a.m. NA Employee E1 stated that she was aware of Resident R58's orders for a two person assist using a sit to stand and completed the lift by herself. During a phone interview on 7/15/22, at 10:50 a.m. the facility Wound Care RN Employee E3 stated, I was outside the room on 3/26/22, I heard a scream, so I ran and Resident R58 was on the floor screaming in pain. That she was transferred with one assist in a sit to stand lift by the NA Employee E1, when she was ordered a two assist in a sit to stand lift. Review of Resident R58's hospital documents Orthopedics Consult Note dated 3/27/22, indicated she fell in the nursing home, orthopedics was consulted for left intertrochanteric femur fracture. Reports stated patient was dropped on her left side during a transfer using a sit to stand lift. Patient stated she does not recall incident. Imaging notes indicated the resident has a slightly displaced (break where bones are not in alignment) left intertrochanteric femur fracture. Review of Resident R58's facility physician progress notes dated 4/19/22, indicated the resident was recently admitted to the hospital with left hip fracture, was not a surgical candidate and returned to the facility as a hospice resident (end of life care focusing on symptom management). During an interview on 7/15/22, at 11 a.m. and 7/18/22, at 1:38 p.m. The Nursing Home Administrator and Director of Nursing (DON) confirmed, that the facility had not provided Resident R58 the correct two person assist with a transfer resulting in actual harm of a left intertrochanteric femur fracture. 28. Pa Code 201.14(a) Responsibility of licensee. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Previously cited 10/6/21, 5/19/21, 4/1/21 and 10/8/20. 28. Pa Code 201.18(b)(1) Management. Previously cited 5/18/21, 4/1/2 and 9/1/20. 28. Pa Code 201.18(e)(1) Management. Previously cited 5/18/21 and 4/1/21. 28. Pa. Code 211.12(d)(1) Nursing services. Previously cited: 5/5/22, 10/6/21, 5/19/21, 4/1/21, 1/27/21 and 9/1/20. 28. Pa. Code 211.12(d)(5) Nursing services. Previously cited 5/5/22, 5/19/21, 4/1/21, and 1/27/21. 28. Pa Code 201.18(b)(1)(e)(1) Management. Previously cited: 10/6/21, 5/18/21, 4/1/21, 9/1/20.

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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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32773 Based on review of facility policies and clinical records, staff interviews and written statements, it was determined that the facility failed to make certain that a resident received adequate supervision and was provided a safe transfer resulting in actual harm when resident fell during a transfer causing resident to sustain a left intertrochanteric femur fracture (breaking of the upper part of the leg bone between the bony prominence near to the hip muscles attachments) for one of eight residents (Resident R58), and failed to adequately maintain equipment to prevent incident for one of eight residents (Resident R70). Findings include: Review of the facility policy Abuse Protection last reviewed 3/22/22, indicated that Neglect is defined as the failure to provide the goods and services necessary to avoid physical harm, mental anguish, or mental illness. Neglect refers to failure through inattentiveness, carelessness, or omission to provide timely, consistent, safety adequate, and appropriate services, treatment of care, including but not limited to nutrition, medication, therapies, and activities of daily living. Review of Resident R58's Minimum Data Set (MDS - periodic review of care needs) dated 5/20/22, indicated she was admitted to the facility on [DATE], Section C Cognitive Patterns, Brief Interview for Mental Status (test of cognitive status) score is 15 (cognitively intact), and her current diagnosis included high blood pressure, diabetes, and left femur fracture. Review of Resident R58's MDS dated [DATE], Section G - Functional Status, Questions G0110b, ADL (activities of daily living) Assistance for Transfer Status, indicated she required an extensive assistance of two or more staff members when transferring from one surface to another. Review of Resident R58's physician order dated 3/24/22, instructed staff to transfer resident with a sit to stand (a type of mechanical lift) and assist times 2 staff. Review of facility employee witness statement dated 3/27/22, not timed, completed by Nurse Aide (NA) Employee E1 indicated that on 3/26/22, when transferring Resident R58, from her chair with the sit to stand. I noticed her head fall to the right and her body start to go limp. We (the roommate's daughter) lowered her to the floor. I called the nurse. She came in and Resident R58 was not responding. After a few times of calling her name she said she wanted to get up she said her leg was feeling pain, and we covered her up, and sent her to the hospital emergency room . Review of facility employee Witness Statement dated 3/26/22, at 4:30 p.m. completed by Registered Nurse (RN) Employee E2, indicated she was alerted to Resident R58's room by NA Employee E1. Upon entering the room resident, she was laying on her back in the supine position (laying on back face up). Resident did respond when her name was called upon assessment the resident began to scream my leg, my leg while guarding her left leg. As staff began to elevate head because she complained of I can't breathe, she yelled louder in extreme pain. This staff instructed staff to keep her as she was lying, not to attempt to move her in anyway, while this nurse called for a transfer to the hospital. That NA Employee E1 stated resident loss consciousness and began to slide out of lift. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During a phone interview on 7/13/22, at 3:15 p.m. NA Employee E1 stated on 3/26/22, she was transferring Resident R58 from her wheelchair to her bed by herself, NA Employee E1 stated that she knew Resident R58 was to have two staff to assist her with the transfer and did the transfer by herself, and Resident R58 passed out on the lift, and the roommates daughter helped her lower the resident to the floor. During an interview on 7/13/22, at 3:24 p.m. Resident R58, stated she broke her hip in March of 2022, that it hurt at the time, and she cannot remember the incident. During an interview on 7/14/22, at 11:30 a.m. that on 3/26/22, RN Employee E2 stated that she heard NA Employee E1 yelling and she went into Resident R58's room and was laying on the floor, during her assessment resident was screaming in pain, and was guarding her leg, which was rotated out, and the resident could not move it. RN Employee E2 stated that Resident R58 was ordered a sit to stand with an assist of two staff, and NA Employee E1 moved her by herself. During a phone interview on 7/15/22, at 10:50 a.m. the facility Wound Care RN Employee E3 stated, I was outside the room on 3/26/22, I heard a screaming and went to Resident R58's room and resident was on the floor screaming in pain. Wound Care RN Employee E3 stated that Resident R58 was transferred with one assist in a sit to stand lift by the NA Employee E1, and the physician orders were assist of two while using a sit to stand lift. Review of Resident R58's hospital documents Orthopedics Consult Note dated 3/27/22, indicated she fell in the nursing home, orthopedics was consulted for left intertrochanteric femur fracture. Reports stated patient was dropped on her left side during a transfer using a sit to stand lift. Patient stated she does not recall incident. Imaging notes indicated the resident has a slightly displaced (break where bones are not in alignment) left intertrochanteric femur fracture. Review of Resident R58's facility physician progress notes dated 4/19/22, indicated the resident was recently admitted to the hospital with left hip fracture, was not a surgical candidate and returned to the facility as a hospice resident (end of life care focusing on symptom management). During an interview on 7/15/22, at 11:00 a.m. and 7/18/22, at 1:38 p.m. The Nursing Home Administrator (NHA) and Director of Nursing (DON) confirmed that the facility failed to provide Resident R58 the correct two person assist with a transfer resulting in a preventable accident and causing accrual harm to Resident R58 resulting in a left intertrochanteric femur fracture. Review of the clinical record indicated that Resident R70 was admitted to the facility on [DATE]. Review of Resident R70's MDS assessments dated 12/3/21, and 5/24/22, included diagnoses of diabetes (a metabolic disorder in which the body has high sugar levels for prolonged periods of time) and heart failure (a progressive heart disease that affects pumping action of the heart muscles). Review of Section G - Functional Status indicated that Resident R70 required physical assistance of two or more persons with bed mobility and transferring. Review of a facility incident report dated 1/26/22, indicated that Resident R70 was being assisted out of bed, and began to slide on the mattress. Resident R70 was lowered to the floor. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of the witness statement written by LPN Employee E34 stated that Resident R70 was in bed and wanted to get up into wheelchair. He was sitting on side of his bed waiting for the lift to help get him to stand up and get into wheelchair. The bed frame is not the right size for the mattress. The mattress belongs to a bari (bariatric) bed and the mattress is on a small single frame. The mattress had no support or frame under the mattress, so the mattress tilted and he was sliding with the mattress to the floor of his room. Review of the fall investigation dated 1/26/22, indicated the intervention to be implemented after the fall was for maintenance to service the bed. During an interview on 7/18/22, at 10:45 a.m. the DON confirmed the facility failed to provide an appropriately sized mattress for Resident R70 causing a fall. During an interview on 7/18/22, at 2:30 p.m. the NHA and DON confirmed that the facility does not have a written policy for resident transfers and the facility failed to ensure that resident was free from preventable accident by failing to provide the adequate supervision of a two person transfer resulting in actual harm of Resident R58 causing a femur fracture and failed to provide the proper sized mattress to prevent an incident for one of eight Resident R70. 28. Pa Code 201.14(a) Responsibility of licensee. Previously cited 10/6/21, 5/19/21, 4/1/21 and 10/8/20. 28. Pa Code 201.18(b)(1) Management. Previously cited 5/18/21, 4/1/2 and 9/1/20. 28. Pa Code 201.18(e)(1) Management. Previously cited 5/18/21 and 4/1/21. 28. Pa. Code 211.12(d)(1) Nursing services. Previously cited 5/5/22, 10/6/21, 5/19/21, 4/1/21, 1/27/21 and 9/1/20. 28. Pa. Code 211.12(d)(5) Nursing services. Previously cited 5/5/22, 5/19/21, 4/1/21, and 1/27/21. 28. Pa Code 201.18(b)(1)(e)(1) Management. Previously cited 5/18/21, 4/1/21.

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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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41984 Based on a review of facility policy, clinical record reviews, and staff interview, it was determined that the facility failed to assess and monitor residents to make certain acceptable parameters of nutritional status were maintained for two of five residents (Resident R91 and Closed Resident Record CR248). Findings include: Review of facility policy Nutrition assessment dated [DATE], indicated a nutrition assessment shall be completed for each resident admitted to the facility. The clinical record indicated that Resident R91 was admitted to the facility on [DATE] with diagnosis that include aphasia(loss of ability to understand/express speech, caused by brain damage), dysphagia (language disorder marked by deficiency in speech), and type 2 diabetes mellitus(chronic condition that affects the way the body processes blood sugar). Review of R91 weight record indicated the following weights: 2/1/2022 116 pounds 5/1/2022- 100.8 pounds 7.5% wt loss x 3 months 6/24/2022 117 pounds 7/3/2022 98.8 pounds 7/8/2022 98.8 pounds The clinical record indicated tube feeding discontinued 3/6/2022. Review of physicians orders dated 7/16/2022 indicated a house supplement was added three times daily. The clinical record indicated that Resident R248 was admitted to the facility on [DATE] with diagnosis that include cirrhosis of the liver (chronic liver damage leading to scarring and liver failure) and chronic obstructive pulmonary disease (lung disease that block airflow). Review of Resident R248 assessment summary report indicated no admission nutriton assessment. During an interview on 7/18/2022 Registered Dietitian Employee E26 confirmed that the facility provided no additional interventions to address weight or complete an assessment as required. 28 Pa. Code: 201.18(b)(1)(e)(1)Management Previously cited: 10/6/21 (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	28 Pa. Code: 201.12(d)(1)(3)(5)Nursing services Previously cited: 5/2/22

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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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 39311 Based on review of facility policy, resident observations and interviews, group interview, and grievance review, it was determined that the facility failed to have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of for four of four group residents (R600, R601, R602 and R603), and seven of 24 residents (R46, R82, R90, R65, R2, R61, and R93). Findings Include: Review of the facility policy Flow of Care dated 3/22/22, indicated that care will be provided to residents as needed to attain and maintain the highest level of functioning, that the provision of targeted care needs shall be documented on the point of care records, and that residents are to have two baths/showers/week unless the resident states otherwise. Review of the facility policy Call Light Response dated 3/22/22, indicated staff will respond to the call light and the resident's request and needs in a timely manner. During a resident group interview on 7/12/22, at 1:07 p.m. Resident's R600, R601, R602 and R603 as a group indicated that cell response is an ongoing problem, especially from 2:00 p.m. to 3:00 p.m. when staff is changing shift, and late call bell response is more of a problem with agency staff. During an observation on 07/12/22, the following was observed: -10:30 a.m. the call light for Resident R41 was noted to be alarming. It is unknown the actual start time of the call light. -10:30 - 10:37 a.m. Therapy Employee E29 walking to different rooms in the hallway, did not answer call light between entering rooms. -10:34 a.m. Surveyor observed room, Resident R41 did not appear in danger. -10:36 a.m. Resident R41 began yelling for help. Surveyor entered the room, Resident R41 stated she needed water, I've been without it for quite a while. -10:37 a.m. Resident R41 began banging on overbed table. -10:39 a.m. Environmental Services (EVS) Employee E27 noted to be in the hallway, did not answer call light. -10:41 a.m. Therapy Employee E29 in hall again, does not answer call light. -10:42 a.m. Resident 41 yelling help, roommate yelled help also, much louder. -10:43 a.m. Resident R41 banging on the table (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-10:44 a.m. Therapy Employees E29 E30 both were in the hallway, neither answered the call light between entering rooms. -10:47 a.m. Resident R41 yelling help -10:49 a.m. Nurse Aide (NA) Employee E30 walked by room, did not answer call lights. -10:50 a.m. EVS Employee E28 walked by room without looking in. -10:53 a.m. Resident R41 continues to bang on the table -10:55 a.m. Director of Nursing entered conference room, and asked surveyor to wait while she answered the call light. -10:57 a.m. Resident R41 received water. During an observation on 07/13/22, the call light for Resident R41 was noted to be on at 10:09 a.m. It is unknown the actual start time of the call light. This call light was not answered until 10:26 a.m. by Registered Nurse (RN) Employee E30 at 10:26 a.m. During an observation on 7/13/22, at 10:40 a.m. Resident R82 she had waited from 1:30 a.m. to 8 a.m. for pain medication. Review of the medication administration record indicated that Resident R82 may take Diluadid (opioid narcotic treat moderate to severe pain) every four hours as needed. No medication was documented as provided from the morning of 7/12/22, until the morning of 7/13/22. During an interview on 7/13/22, at 2:47 p.m. Resident R90 stated it takes up to 20 minutes for staff to arrive and answer calls and that agency staff take a long time to bathe her. During an interview on 7/13/22, at 2:55 p.m. Resident R65 stated there are not enough nurses and aides working. During an interview on 7/13/22, at 3:01 p.m. when asked about call lights, Resident R41 stated sometimes they just don't show up. The 3-11 shift is really bad. During an interview on 7/13/22, at 3:12 p.m. Resident R2 stated that call lights take a long time. During an observation on 07/13/22, the following was observed: -3:40 p.m. the call light for Resident R61 was noted to be alarming. Surveyor observed resident, who appeared safely in bed. It is unknown the actual start time of the call light. -4:04 p.m. Resident R61 was interviewed, and she stated she was wet and uncomfortable and stated they don't have enough staff. I haven't been up all day. The brief on Resident R61 was visibly wet. Surveyor left room to find assistance. -4:06 p.m. Informed Nursing Home Administrator at the nurse's station that Resident R61 needed incontinence care. (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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-4:09 p.m. Observed staff entering Resident R61's room. During an interview on 7/18/22, at 10:46 a.m. Resident R93 was in his room with the call bell ringing, and stated I told the nurse aide I wanted out of bed at 8:30 a.m. and it is now past 10:30 a.m., and I am still sitting in bed. I still need my morning medications and a dressing change, and now I need changed. It's like this every morning. A review of grievances related to long call lights and lack and/or delay of care from 4/1/22 - 6/30/22, revealed the following: -4/11/22 - call light time concern. -4/18/22 - erratic call lighy times. During an interview on 12/30/21, at 2:00 p.m. the Director of Nursing was informed of the observations and confirmed the facility failed to have sufficient nursing staff to provide nursing and related services to 11 of 24 residents. 28 Pa. Code: 201.14(a) Responsibility of licensee. Previously cited: 8/20/20, 4/1/21, 5/19/21, 10/6/21. 28 Pa. Code: 201.18(e)(6) Management. 28 Pa. Code: 211.12(a) Nursing services. 28 Pa. Code: 211.12(c) Nursing services. Previously cited: 8/6/21 28 Pa. Code 211.12(d)(1)(2) Nursing services Previously cited: 9/1/20, 1/27/21, 4/1/21, 5/19/21, 10/6/21, 5/5/22. 28 Pa. Code: 211.12(d)(3) Nursing services. Previously cited: 9/1/20, 4/1/21, 10/6/21. 28 Pa. Code: 211.12(d)(4) Nursing services. 28 Pa. Code: 201.20(a) Staff development.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395434	A. Building B. Wing	07/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MT Lebanon Rehabilitation and Wellness Center	350 Old Gilkeson Road Pittsburgh, PA 15228

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 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41984 Based on a review of facility assessment and staff interviews, it was determined that the facility failed to employ staff to carry out the daily functions of the Dietary Department (Dietary Manager) Findings include: A review of the Facility assessment dated [DATE], indicated one Full Time Dietary Manager would be on staff. During the kitchen tour Cook Employee E17 indicated that they haven't had a manager for a few weeks, was unsure of the date. During an interview on 7/13/2022, at 2:15 p.m. the Nursing Home Administrator confirmed that there has not been a Kitchen Manager since 6/24/2022 as required. 28 Pa. Code 211.6(c)(d) Dietary services