STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395067	A. Building B. Wing	01/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Green Ridge Care Center	2741 Boulevard Avenue Scranton, PA 18509

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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 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Plan the resident's discharge to meet the resident's goals and needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39929 Based on a review of clinical records and staff interviews it was determined the facility failed to develop and implement an individualized discharge plan for one of 19 residents reviewed (Resident 3) to reflect the resident's discharge goals. Findings Include: Clinical record review revealed that Resident 3 was admitted to the facility on [DATE], with diagnoses to include atrial fibrillation (an irregular and often very rapid heart rhythm). Review of a quarterly Minimum Data Set Assessment (MDS- a federally mandated standardized assessment process completed at specific intervals to plan resident care) dated January 15, 2025, indicated the resident had a BIMS (brief interview mental screener that aids in detecting cognitive impairment) score of 15 indicating she was cognitively intact. A review of Resident 3's social service notes, revealed a note dated August 28, 2024, indicating the resident would like to be discharged home when able. The next social service notes regarding discharge from the facility were not until November 18, 2024, indicating the resident was to be discharged home on December 13, 2024. During the survery ending January 31, 2025 there was no further documentation regarding discharge to home and no documentation regarding the reason the resident did not discharge home on December 13, 2024. A review of the resident's comprehensive care plan, reviewed during the survey ending January 31, 2025, revealed no documented evidence that an individualized discharge plan was revised, as needed to reflect the resident's current desire for discharge or long-term placement at the facility. During an interview with the Nursing Home Administrator on January 30, 2025, at 12:00 PM confirmed there was no documented evidence of a current discharge goal and plan for this resident. 28 Pa. Code 201.18(b)(1) Management 28 Pa. Code 201.29 (a) 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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43944 Based on clinical record review, facility policy review, and staff interviews, the facility failed to provide effective pain management, administer pain medication as prescribed by the physician, and attempt non-pharmacological interventions prior to administering narcotic pain medication prescribed on an as-needed (PRN) basis for one (1) of three (3) residents sampled for pain (Resident 18). Findings include: A review of the facility's policy titled Pain Management, with a policy review date of December 2024, indicated that an evaluation of pain presence and severity should occur using the appropriate pain scale (numeric pain rating scale, face rating scale, or verbal descriptor scale). The policy further stated that non-pharmacological interventions will be attempted prior to the administration of PRN (as needed) pain medications. If non-pharmacological interventions are ineffective, then when multiple PRN medications are available with corresponding intensity ratings, the resident will receive the medication prescribed for the corresponding pain rating. Documentation of medication administration and effectiveness is required in the electronic medication record (eMAR). A review of the clinical record revealed that Resident 18 was admitted to the facility on [DATE], with diagnoses to include fibromyalgia (is a disorder that affects muscle and soft tissue characterized by chronic muscle pain, tenderness, fatigue and sleep disturbances), rheumatoid arthritis (a chronic inflammatory disorder affecting small joints in the hands and feet characterized by painful swelling in the affected areas) and complete rotator cuff tear of the right shoulder (a complete tear of the connecting muscle to bone of the shoulder, characterized by pain of the affected shoulder). A review of Resident 18's physician orders revealed the following PRN pain medication orders: Percocet 5/325mg (narcotic pain medication) one tablet by mouth every four hours as needed (PRN) for severe pain initially ordered on December 31, 2024, and discontinued January 2, 2025. Percocet 5mg (narcotic pain medication) one tablet by mouth every eight hours as needed (PRN) for severe pain initially ordered January 19, 2025, and discontinued January 20, 2025. A review of the resident's December 2024 and January 2025 Medication Administration Record (MAR) revealed the following: The PRN Percocet 5/325mg was administered two times in December: December 31, 2024, at 4:18 PM - medication administered for a pain scale of 3 (mild pain). December 31, 2024, at 9:04 PM - medication administered for a pain scale of 5 (moderate pain). The PRN Percocet 5/325mg was administered three times in January: January 1, 2025, at 9:04 AM - medication administered for a pain scale of 6 (moderate pain). (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	January 1, 2025, at 5:42 PM - medication administered for a pain scale of 6 (moderate pain). January 6, 2025, at 9:36 AM - medication administered for a pain scale of 6 (moderate pain). The PRN Percocet 5mg was administered once in January: January 19, 2025, at 8:58 PM - medication administered for a pain scale of 3 (mild pain). A further review of the resident's January 2025 MAR revealed that the PRN Percocet was administered a total of four times in January. In all instances, no non-pharmacological interventions were attempted prior to administration. Additionally, three of the four doses were administered for pain levels of mild to moderate pain, despite the medication being prescribed only for severe pain. An interview with the Nursing Home Administrator and Director of Nursing on January 30, 2025, at approximately 2:00 PM, confirmed that there was no evidence that non-pharmacological interventions were consistently attempted and documented as ineffective prior to the administration of PRN pain medication. Additionally, they confirmed that the staff administered narcotic pain medication ordered for severe pain to Resident 18 when the resident's documented pain levels were only mild to moderate. The facility administered narcotic pain medication inappropriately for pain levels lower than the prescribed severity and failed to use alternative pain management strategies before resorting to medication. 28 Pa. Code 211.5(f)(vii) Medical records 28 Pa. Code 211.12 (c)(d)(1)(5) Nursing Services

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43944 Based on clinical record and staff interview, it was determined the facility failed to assure the presence of documented evidence of clinical necessity for administration of an antibiotic drug for two residents out of five sampled residents for unnecessary medication prescribing practices (Residents 34 and 71). Findings included: A review of Resident 34's clinical record revealed that the resident was admitted to the facility on [DATE], with diagnoses that included dementia and congestive heart failure (CHF - is a condition where the heart is unable to pump blood effectively). A review of a facility documentation entitled Infection Control - Infection Tracker with McGeer's Criteria 2024 assessment (an algorithm that uses criteria to make an empiric diagnosis of UTI in nursing home residents. For resident's that do not have an indwelling urinary catheter and with at least three of the following signs and symptoms must be present prior to a practitioner prescribing antibiotic therapy include a fever (temperature of at least 38 C [100.4 F]), new or increased frequency, urgency, or burning on urination, new flank or suprapubic pain or tenderness, change in character of urine, and worsening of mental or functional status) dated December 6, 2024, at 3:59 PM, and recorded on December 11, 2024, at 3:59 PM, revealed that the form was initiated due to a suspected UTI. Further review of the completed infection tracker McGeer's Criteria form revealed that Resident 34 did not have a fever, rigors (feeling cold or having chills), or new on-set hypotension (low blood pressure), without alternate site of infection, no acute dysuria (burning sensation when urinating), no leukocytosis (is the presence of more white blood cells than normal, which can indicate infection, inflammation, injury or immune system disorders), and no gross hematuria (presence of red blood cells in the urine), increased incontinence (involuntary loss of large or small amounts of urine), increased urgency (need to urinate), or increased frequency). A review of Resident 34's clinical record revealed a nurses' progress note dated December 4, 2024, at 2:17 PM, revealed the facility's contracted CRNP (certified registered nurse practitioner) was in the facility to assess the resident and ordered a urine analysis (UA an analysis that includes various tests to examine the urine contents for any abnormalities that indicate a disease condition or infection)with a culture and sensitivity (C & S a method to grow and identify bacteria that may be in the urine. The sensitivity test helps select the best medicine to treat the infection). Further review of nurses' progress notes dated December 6, 2024, at 2:07 PM, revealed urine culture results showed a result of greater than 100, 000 colonies/ml (significant number of bacteria in the urine that may cause an infection) A review of physician's orders dated December 6, 2024, at 4:56 PM, revealed orders for Cefdinir (antibiotics) 300 mg twice per day for seven days related to UTI (urinary tract infection). (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The resident lacked essential clinical indicators such as fever, dysuria, leukocytosis, or gross hematuria. The only criterion met was a urine culture with >100,000 CFU/mL of a single organism, which alone was insufficient to justify antibiotic therapy. As a result, the resident received fourteen doses of an unnecessary antibiotic. During an interview with the facility's Infection Preventionist (IP) on January 30, 2025, at 11:20 AM, confirmed that Resident 34 did not meet the requirements for antibiotic treatment. A review of Resident 71's clinical record revealed the resident was admitted to the facility on [DATE], with diagnoses that included type II diabetes (a condition results from insufficient production of insulin, causing high blood sugar), dysphagia (difficulty swallowing), and cerebral infarction with weakness (a medical condition that occurs when the blood flow to the brain is disrupted due to issues with the arteries that supply it and the lack of sufficient blood supply to brain cells deprives them of oxygen and critical nutrients, potentially leading to the death of brain cells). A review of nurses' progress notes in Resident 71's clinical record dated November 15, 2024, at 9:35 PM, revealed the resident was catheterized (is a medical procedure used to drain the bladder) to obtain urine specimen (refers to a sample of urine collection from a patient for diagnostic tests).A CBC (complete blood count that checks different arts of the blood such as the white blood cells to identify infection). A physician's order for Rocephin (antibiotic) IM (intramuscular injection that delivers medication deep into muscle tissue, allowing rapid absorption). A review of the resident's laboratory results dated [DATE], at 8:27 AM, revealed the urinalysis results were unremarkable, urine culture showed no growth, and WBC (white blood cells measures the number of white blood cells in your blood, which are part of your immune system) elevated at 13.05 (reference range for normal parameters 4.0 - 10.80). Additionally, nursing progress notes dated November 16, 2024, through November 18, 2024, documented that the Resident 71's vital signs (temperature, pulse, blood pressure, and respirations) were documented within normal parameters. Rocephin was administered for two days without meeting McGeer's Criteria or having laboratory evidence of an infection During an interview with the facility's Director of Nursing (DON) on January 30, 2025, at 1:15 PM, reported that prior to initiating an antibiotic and as a part of the facility's antibiotic stewardship program licensed nursing staff did not complete the required Infection Tracker form with McGeer's Criteria - 2024 to clinically justify the use of an antibiotic. Additionally, the DON reported that staff did not complete the form as per the antibiotic stewardship program and confirmed that Resident 71's prescribing physician was aware that his signs and symptoms did not meet McGeer's protocol for prescribing an antibiotic. The DON confirmed the facility failed to assure that Resident 71's medication regimen was free from unnecessary medications, Rocephin, and failed to meet antibiotic prescribing practices. 28 Pa. Code 211.2 (3) Medical Director 28 Pa. Code 211.9 (k) Pharmacy Services (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	28 Pa. Code 211.12 (d)(1)(3) Nursing Services

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43944 Based on review of clinical records and staff interview, it was determined the facility failed to offer routine annual dental services for one Medicaid payor source (Resident 23) out of 19 sampled residents. Findings include: Review of Resident 23's clinical record revealed admission to the facility on [DATE], and the resident's payor source was Medicaid. A review of nurses' progress notes in the resident's clinical record dated July 31, 2024, at 1:39 PM, revealed that the facility's contracted CRNP (certified registered nurse practitioner) in to see resident due to complaints of left sided facial pain. NON (new orders noted) for Clindamycin (is a medication used to treat a wide variety of bacterial infections) 300 mg PO (orally) every six hours for 7 days for parotitis (is a serious gum infection that damages the soft tissue around teeth). Further review of Resident 23's clinical record failed to reveal that the facility offered dental services from November 16, 2022, until October 20, 2024. During an interview with the Director of Nursing (DON)on November 30, 2025, at 9:20 AM, confirmed that the facility failed to assure that Resident 23 was annually offered routine dental services. 28 Pa. Code 211.12 (c)(d)(3)(5) Nursing services

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39929 Based on a review of clinical records, staff interview, facility policy, and the facility's infection assessment tool, it was determined the facility failed to consistently implement its antibiotic stewardship protocols for initiating antibiotic use in accordance with the established infection prevention and control guidelines for two residents out of 19 sampled (Residents 34 and 71). Findings included: A review of a facility policy entitled Antibiotic Stewardship last reviewed December 2024, indicated that antibiotics will be prescribed and administered to residents under the guidance of the facility's Antibiotic Stewardship Program. The policy stated the facility will monitor and track new antibiotics start rates and antibiotic days of therapy monthly. It also required that antibiotic use protocols address prescribing practices, including documentation of the indication, dose, and duration of the antibiotic, review of laboratory reports to determine necessity, and completion of an infection assessment before prescribing. Additionally, the policy outlined monitoring procedures such as antibiotic use reports, antibiotic resistance reports, and the use of McGeer's criteria for determining the need for antibiotic therapy. A review of Resident 34's clinical record revealed that the resident was admitted to the facility on [DATE], with diagnoses that included dementia and congestive heart failure (CHF - is a condition where the heart is unable to pump blood effectively). A review of the facility's infection tracker form, entitled Infection Control - Infection Tracker with McGeer's Criteria, dated December 6, 2024, and recorded on December 11, 2024, indicated that the form was initiated due to a suspected urinary tract infection (UTI). However, the completed assessment revealed that Resident 34 did not meet the McGeer's criteria to support the initiation of antibiotic therapy. Specifically, the resident did not have a fever, rigors, acute dysuria, leukocytosis, gross hematuria, or other signs and symptoms necessary to meet at least three criteria for a UTI diagnosis. Despite only meeting one criterion, a physician's order dated December 6, 2024, at 4:56 PM, prescribed Cefdinir 300 mg orally twice per day for seven days. A review of Resident 34's Medication Administration Record (MAR) for December 2024 revealed that the resident received 14 doses of Cefdinir without meeting the documented criteria for initiation of antibiotic therapy. The facility's failure to adhere to antibiotic stewardship protocols resulted in the unnecessary administration of antibiotics. A review of Resident 71's clinical record revealed that the resident was admitted to the facility on [DATE], with diagnoses that included type II diabetes (a condition results from insufficient production of insulin, causing high blood sugar), dysphagia (difficulty swallowing), and cerebral infarction with weakness (is a medical condition that occurs when the blood flow to the brain is disrupted due to issues with the arteries that supply it and the lack of sufficient blood supply to brain cells deprives them of oxygen and critical nutrients, potentially leading to the death of brain cells). (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A nursing progress note dated November 15, 2024, at 9:35 PM, indicated that Resident 71 was catheterized ((is a medical procedure used to drain the bladder) to obtain a urine specimen. Orders were noted for STAT laboratory testing, including a complete blood count (CBC) and a basic metabolic panel (BMP), as well as an order to initiate Rocephin 1 gram intramuscularly daily for two days due to an elevated white blood cell (WBC) count. A review of the resident's laboratory results dated [DATE], at 8:27 AM, revealed that urinalysis results were unremarkable, the urine culture showed no growth, and WBC was elevated at 13.05 (reference range: 4.0 - 10.80). However, nursing progress notes from November 16, 2024, through November 18, 2024, documented that the resident's vital signs, including temperature, pulse, blood pressure, and respirations, remained within normal parameters. Despite the lack of clinical signs or symptoms of infection, the resident received two doses of Rocephin, indicating the facility's failure to ensure antibiotic therapy was supported by documented clinical necessity. During an interview with the facility's Infection Preventionist (IP) on January 30, 2025, at 11:20 AM, confirmed that the facility failed to implement antibiotic stewardship protocols for residents 34 and 71. This failure contributed to the initiation and continuation of antibiotic therapy without documented evidence of clinical necessity, inconsistent use of infection surveillance tools, and noncompliance with infection prevention and control guidelines. The facility failed to adhere to its established antibiotic stewardship program by allowing the initiation and continuation of antibiotic therapy without documented clinical indications. guidelines. Cross Refer F757 28 Pa. Code 211.10(a)(d) Resident care policies 28 Pa. Code 211.12 (c)(d)(1)(3)(5) Nursing services