

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395103	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/24/2024
NAME OF PROVIDER OR SUPPLIER Elan Skilled Nursing and Rehab, A Jewish Senior LI		STREET ADDRESS, CITY, STATE, ZIP CODE 1101 Vine Street Scranton, PA 18510	

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)
<p>F 0557</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48276</p> <p>Based on observations and staff interviews, it was determined the facility failed to conduct meal service in a manner respectful of each resident's personal dignity for one of nine residents observed at the breakfast meal (Resident 43).</p> <p>Findings include:</p> <p>A clinical record review revealed Resident 43 was admitted to the facility on [DATE], with diagnoses that included dementia (a condition characterized by the loss of cognitive functioning such as thinking, remembering, and reasoning, to such an extent that it interferes with a person's daily life and activities).</p> <p>A review of an admission Minimum Data Set assessment (MDS - a federally mandated standardized assessment process conducted periodically to plan resident care) dated July 25, 2024, revealed that Resident 43 is severely cognitively impaired with a BIMS score of 03 (Brief Interview for Mental Status- a tool within the Cognitive Section of the MDS that is used to assess the resident's attention, orientation, and ability to register and recall new information; a score of 01-07 indicates severe cognitive impairment).</p> <p>A Speech Language Pathology Discharge Summary dated August 3, 2024, revealed severe deficits in Resident 43's problem-solving ability and memory. The summary indicated the resident's prognosis to maintain her current level of functioning is good with consistent staff follow-through. Discharge recommendations indicated the resident needs verbal, visual, and demonstration cues for cognition and safety awareness.</p> <p>An Occupational Therapy Discharge Summary dated August 3, 2024, revealed resident 43 requires supervision and/or touching assistance when eating.</p> <p>A review of Resident 43's care plan revealed she has a deficit related to impaired balance. Interventions in place to assist Resident 43 with her goal of being free from complications related to her self-care deficit include having limited staff assistance when eating and utilizes the feeding assistance program.</p> <p>Further review of Resident 43's care plan revealed she has the potential for altered nutrition related to leaving meals uneaten. The resident's goal is to consume 50% to 100% of meals and fluids.</p> <p>(continued on next page)</p>

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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<p>F 0557</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An observation on September 24, 2024, revealed Resident 43 located in the Unit 3 resident dining area. At 9:02 AM, a nurse aide placed Resident 43's meal in front of her and then sat near another resident at the same table. Resident 43 was observed sitting with her plate of food in front of her for 25 minutes while other residents were assisted with eating, including a resident sitting next to her at the same table. During the 25 minutes, staff did not cue the resident or encourage the resident to attempt to eat independently. At 9:27 AM, Employee 3, Licensed Practical Nurse (LPN), was observed cutting Resident 43's meal, then assisting her with eating. During the observation, staff were observed actively assisting other residents.</p> <p>During an interview on September 24, 2024, at approximately 10:30 AM, Employee 1, Nurse Aide, indicated that residents on Unit 3 require a lot of assistance with eating. She explained the unit is sometimes limited on staffing and meals can take hours before all the residents receive the assistance needed.</p> <p>During an interview on September 24, 2024, at approximately 10:40 AM, Employee 2, Nurse Aide, indicated that meals can take about 2 hours before all the residents are fed that need assistance. She indicated that other staff help, but there are about 15 residents that are completely dependent on staff to eat their meals.</p> <p>During an interview on September 24, 2024, at approximately 10:45 AM, Employee 3, LPN, acknowledged that Resident 43 was left unassisted for 25 minutes. She explained she was assisting other residents at the time. She indicated that today is a good day for staffing, but at times the residents wait even longer because there is not enough staff to ensure that all residents get the assistance needed during meals. Employee 1, LPN, acknowledged the resident's tray should not have been placed in front of her until staff were able to provide her the required assistance to eat her meal.</p> <p>A review of a resident census document revealed 39 residents living on Unit 3. The document indicated that 13 residents were able to independently eat meals, and the remaining 26 residents needed varying levels of supervision and assistance with eating.</p> <p>During an interview on September 24, 2024, at approximately 1:00 PM, the Director of Nursing (DON) confirmed that Unit 3 had a high acuity of residents that required assistance with meals. The DON confirmed that it is the facility's responsibility to ensure residents are treated with respect and dignity. The DON acknowledged that residents should not be sitting with meals in front of them waiting for 25 minutes while other residents are assisted with eating at the same table.</p> <p>28 Pa. Code 201.29(a) Resident rights.</p> <p>28 Pa. Code 211.12(d)(3)(5) Nursing services.</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48276</p> <p>Based on review of clinical records and staff interview, it was determined the facility failed to maintain accurate and complete clinical records for one of 10 sampled residents (Resident CR1).</p> <p>Findings include:</p> <p>A clinical record review revealed Resident CR1 was admitted to the facility on [DATE], with diagnoses that included cerebral infarction (brain damage that results from a lack of blood).</p> <p>A clinical record review revealed physician's orders for Resident CR1 to receive hospice services initiated on March 26, 2023, and for monthly weight monitoring to be discontinued on March 28, 2023.</p> <p>A review of a documentation survey report for August 2024 revealed 18 meals that had no documented information regarding Resident CR1 nutritional intake (percentage of meal eaten or amount of liquids consumed).</p> <p>A review of Resident CR1's progress notes from August 1, 2024, through August 29, 2024, revealed no documentation of the resident's nutritional intake.</p> <p>Further review of the clinical record revealed Resident CR1 and was discharged from the facility to home with external hospice provider services on August 29, 2024.</p> <p>During an interview on September 26, 2024, at approximately 1:00 PM, the Director of Nursing (DON) indicated the facility is responsible for ensuring each resident's clinical record is accurate and complete. The DON confirmed the facility failed to document Resident CR1's nutritional intake. The DON was unable to explain why there was no documentation regarding resident CR1's nutritional intake for 18 meals in August 2024.</p> <p>28 Pa. Code 211.5(f)(ii) Medical records.</p> <p>28 Pa. Code 211.12(d)(1)(5) Nursing services.</p>		