STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395103	A. Building B. Wing	06/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elan Skilled Nursing and Rehab, A Jewish Senior LI	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)
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** Based on a review of clinical records, select facility policy, facility investigative documentation, and staff and resident interviews, it was determined the facility failed to implement adequate accident prevention measures when staff transported a resident identified as being at risk for falls through the hallway in a shower chair, for one out of 8 residents sampled (Resident 1) resulting in actual harm including a frontal scalp hematoma. This deficiency is cited as past noncompliance. Findings include: A review of the facility policy titled Personal Hygiene, last reviewed by the facility in June 2026, revealed it is the facility's policy that residents should not be transported to the shower room in the shower chair. A review of a medical guideline titled Falls and Fall Prevention in the Post-Acute and Long-Term Care Setting Clinical Practice Guideline developed by the Post-Acute and Long-Term Care Medical Association (PALTmed) and published February 2, 2026 revealed that In the PALTC setting, patients taking anticoagulants who experience a fall should be sent for imaging if a reliable patient or witness reports evidence of head trauma or a credible history of trauma. Clinical record review for Resident 1 revealed the resident was admitted to the facility on [DATE], with diagnoses including paraplegia (partial or complete paralysis of the lower half of the body with involvement of both legs that is usually due to injury or disease of the spinal cord in the thoracic or lumbar region). An Annual Minimum Data Set assessment (MDS, a federally mandated standardized assessment process conducted at specific intervals to plan resident care) dated May 5, 2026, indicated the resident was cognitively intact with a BIMS score of 15 (brief interview for mental status, a tool to assess the residents attention, orientation and ability to register and recall new information, a score of 13-15 equates to being cognitively intact) and required extensive staff assistance with activities of daily living (basic self-care tasks such as bathing, dressing, toileting, transferring, and moving about).A review of Resident 1's individualized care plan revealed the resident had an activities of daily living (ADLs, basic self-care tasks such as bathing, dressing, toileting, transferring, and moving about) self-care deficit related to muscle spasms and activity intolerance (reduced ability to tolerate physical activity), initiated on May 5, 2022. The care plan directed staff to provide extensive assistance with transfers using two staff members and a Hoyer lift (a mechanical lifting device used to safely transfer individuals who cannot independently stand or bear weight). The care plan also identified Resident 1 as being at risk for falls related to impaired mobility and balance, with interventions intended to reduce the likelihood of injury during transfers and movement throughout the facility. Despite these identified risks and planned interventions, staff transported Resident 1 through the hallway while the resident remained seated in a shower chair, contrary to facility policy. Review of the clinical record revealed a physician's order initiated May 5, 2022, for Apixaban (Eliquis), an anticoagulant (blood thinner that reduces blood clotting and increases the risk of bleeding following an injury), to be administered 5 milligrams by mouth every morning and every evening. A nurses' progress note dated June 17, 2026, at 9:20 PM documented Resident 1 experienced a witnessed fall from a shower chair. The note indicated staff found the resident lying face down in the hallway near the fire doors. Resident 1 reported head pain rated three on a zero to 10 pain scale. Nursing (continued on next page)

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

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F 0689 Level of Harm - Actual harm Residents Affected - Few	documentation indicated neurological assessments performed after the fall did not identify changes in the resident's level of consciousness, orientation, or neurological status. The note further documented the resident was receiving Eliquis. The physician was notified, and recommended transfer to the Emergency Department. Resident 1 refused transfer at that time. Facility investigative documentation dated June 17, 2026, revealed Employee 1 (Nurse Aide) and Employee 2 (Nurse Aide) transported Resident 1 from her room to the shower room while the resident remained seated in a shower chair. When the shower chair transitioned from the carpet to the laminate flooring, Resident 1 fell from the chair and struck the left side of her face on the floor. Staff assessed the resident and identified a hematoma (collection of blood underneath the skin) on the left side of the forehead. Resident 1 required a mechanical lift and assistance from three staff members to be lifted safely from the floor. The physician was notified and recommended emergency department evaluation; however, the resident declined transfer. Review of the investigation revealed the shower chair was used to transport the resident through the hallway contrary to facility policy. As part of the investigation, Employee 1 and Employee 2 were reeducated that transporting residents to the shower room in shower chairs is not an acceptable practice. A written witness statement dated June 17, 2026, completed by Employee 1 acknowledged Resident 1 was transported in the shower chair despite facility policy because the resident requested transportation in the shower chair to avoid multiple transfers with a mechanical lift.A written witness statement dated June 17, 2026, completed by Employee 2 likewise acknowledged Resident 1 was transferred into the shower chair in the resident's room despite facility policy because the resident requested this method of transport. These statements confirmed that staff transported Resident 1 in the shower chair despite acknowledging the practice was contrary to the facility policy. Although Resident 1 requested transportation in the shower chair, staff remained responsible for implementing safe transportation practices consistent with the residents assessed fall risk and the facility's established policy. Facility investigative documentation revealed Resident 1 complained of wrist pain at approximately 8:30 AM on June 18, 2026. Staff again discussed emergency evaluation with the resident, who agreed to transfer to the Emergency Department at 9:00 AM. Hospital records dated June 18, 2026, revealed Resident 1 had X-rays of the wrist, chest, and pelvis, which identified no fractures. Computed tomography (CT, a specialized X-ray examination that produces detailed internal images) of the brain and cervical spine was completed because of the resident's head injury and anticoagulant therapy. The CT scan identified a frontal scalp hematoma without evidence of an acute intracranial hemorrhage (bleeding inside the skull) or spinal injury. Interview on June 24, 2026, at 10:30 AM, revealed that Resident 1 was observed with purple and yellow bruising on the left side of the face, purple and yellow bruising beneath both eyes, and a healing yellow scabbed area on the left forehead. When asked how the injuries occurred, Resident 1 stated that on June 17, 2026, staff transported her from her room to the shower room while she remained seated in a shower chair. Resident 1 explained she has paraplegia (paralysis affecting both legs) and requires a Hoyer lift for transfers. Resident 1 stated she preferred transportation in the shower chair because it reduced the number of mechanical lift transfers required during showering. She stated that while staff were transporting her through the hallway, the shower chair struck the transition between carpet and hard flooring, causing her to fall forward onto the floor, striking her face. Resident 1 stated she initially refused transfer to the hospital; however, staff encouraged her to seek evaluation, and she agreed to go the following morning. Resident 1 stated she was thankful nothing was broken, reported minimal pain other than itching from the healing hematoma, and stated she was mostly embarrassed by the situation. This deficient practice resulted in actual harm. Resident 1 sustained a frontal scalp hematoma with extensive facial bruising requiring emergency department evaluation, diagnostic imaging, and ongoing clinical monitoring. This deficiency is cited as past noncompliance. The findings were reviewed with the Assistant Nursing Home Administrator and the Director of Nursing on June 24, 2026, at approximately 2:00 PM. Corrective actions implemented by the facility included: Following the incident, Resident 1 was (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	immediately assessed by nursing staff. After initially refusing emergency department evaluation, the resident agreed to transfer the following morning for diagnostic testing. Nursing staff received reeducation regarding the facility's Personal Hygiene policy prohibiting transportation of residents to the shower room while seated in shower chairs. Laminated reminder signs were placed in shower rooms instructing staff not to use shower chairs for resident transportation. Nursing administration implemented random transportation safety audits conducted daily for five consecutive days, weekly for three weeks, and monthly for two months. Audit results were reviewed through the facility's Quality Assurance and Performance Improvement (QAPI) Committee to evaluate ongoing compliance and identify any additional corrective measures. The facility achieved substantial compliance with this deficient practice on June 19, 2026. 28 Pa. Code 211.10 (d) Resident care policies. 28 Pa. Code 211.12 (d)(3)(5) Nursing services.