STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395249	A. Building B. Wing	02/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hampton House Rehabilitation and Nursing Center	1548 Sans Souci Parkway Wilkes Barre, PA 18702

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41460 Based on observation, review of select facility policy and clinical records, and staff interview, it was determined that the facility failed to promptly act upon known risk factors, including immobility, for pressure sore development and timely implement individualized measures to prevent pressure sore development and promote healing for one of six residents sampled with pressure sores (Resident 1). Findings include: According to the US Department of Health and Human Services, Agency for Healthcare Research & Quality, the pressure ulcer best practice bundle incorporates three critical components in preventing pressure ulcers: Comprehensive skin assessment, Standardized pressure ulcer risk assessment and care planning and implementation to address areas of risk. ACP (The American College of Physicians is a national organization of internists, who specialize in the diagnosis, treatment, and care of adults. The largest medical-specialty organization and second-largest physician group in the United States) Clinical Practice Guidelines indicate that the treatment of pressure ulcers should involve multiple tactics aimed at alleviating the conditions contributing to ulcer development (i.e. , support surfaces, repositioning and nutritional support); protecting the wound from contamination and creating and maintaining a clean wound environment; promoting tissue healing via local wound applications, debridement and wound cleansing; using adjunctive therapies; and considering possible surgical repair. Review of a facility policy entitled Skin Integrity indicated that the purpose was to provide a systemic approach and monitoring process for skin and decrease pressure ulcer formation by identifying those residents who are at risk and developing interventions. Provide guidelines for optimal skin care to promote healing to residents with all identified alterations in skin integrity including surgical incisions. If an identified risk is present the interventions will be documented in the baseline plan of care and or comprehensive care plan. Initiation of positioning schedule to meet individual resident needs and minimize concentrated pressure to skin. Positioning devices such as pillows or foam wedges are recommended to keep bony prominences from direct contact with one another, consider adding therapy screen for any positioning recommendations. Cleansing/Incontinent care - rinse with warm water pat dry do not massage bony prominences, may apply moisture barrier cream, or follow center incontinence protocol. Promote activity level, mobility, and range of motion as appropriate. (continued on next page)

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of current facility policy entitled Pressure Ulcer Treatment indicated that the purpose of this procedure is to provide guidelines for the care of existing pressure ulcers and the prevention of additional pressure ulcers. Review the resident's care plan to assess for any special needs of the resident. Notify the supervisor if the resident refuses the procedure and interventions and report the information in accordance with the facility policy and professional standards of practice. Review of Resident 1's clinical record revealed that the resident was admitted to the facility on [DATE], with diagnoses of a fracture of right femur (thigh bone), reduced mobility (changes in walking pattern), difficulty walking, moderate protein calorie malnutrition and dysphagia (difficulty swallowing). A review of the resident's care plan dated January 9, 2024, revealed that the facility identified that the was at risk for skin breakdown and actual impaired skin integrity related to fragile skin, peripheral vascular disease, chronic arterial disease, and multiple cardiac diagnosis. The facility's planned interventions for pressure ulcer prevention and management were to encourage good nutrition and hydration to promote healthier skin, encourage leg elevation as tolerated, moisturize upper and lower extremities daily, prevalon boots (heel protectors that help reduce risk of bedsores by keeping the heel always floated and relieve pressure), bariatric specialty mattress and chair pad and treatments as ordered. A review of the resident's care plan dated January 9, 2024, identified that the resident had a surgical wound to his left first toe, status post femoral bypass with graph from left leg with multiple surgical areas related to femoral/tibial bypass and was non-compliant with being non-weight bearing. The facility's planned interventions were to monitor the surgical site for signs of infection, non-weight bearing status to the left lower extremity, and to document measurements of wounds weekly. Review of an admission Minimum Data Set Assessment (MDS- a federally mandated standardized assessment process conducted periodically to plan resident care) assessment dated [DATE], revealed that the resident had severe cognitive impairment and required extensive assistance with bed mobility (how a person moves and turns in bed) and transfers (moves from one surface to another) and was at risk for developing pressure areas. A review of the facility's record of the planned tasks to care for the resident during the months of January 2024 and February 2024 revealed no evidence of the implementation of a positioning schedule, utilization of pressure reducing wedges or pillows, or application of barrier creams according to policy. An admission Braden Observation assessment (a tool to assess risk for pressure sores) completed by a Registered Nurse (RN) dated February 9, 2024, at 3:08 PM, revealed that the resident scored 17 indicating that the resident was at risk for pressure ulcers. A nursing progress note dated February 16, 2024, at 8:10 AM revealed that staff heard the resident yelling and found the resident lying on the floor in the resident's room, next to his bed on his left side. The resident stated I was trying to go to the bathroom and I fell . The physician was made aware and x-ray imaging was ordered. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the results of the x-ray of the right hip dated February 16, 2024, at 10:19 AM revealed that the resident had an acute fracture just below the great trochanter (upper part of thigh when the bone meets the hip). Nursing notes dated February 16, 2024, at 12:19 PM revealed that the resident was admitted to the hospital with for a right hip fracture. A review of record entitled General Evaluation - Physical Therapy from the hospital dated February 17, 2024, at 1:32 PM revealed that the resident would have partial flat foot weight bearing status to his right lower extremity and continue non-weight bearing status to his left lower extremity related to past surgical left toe amputation and femoral/tibial bypass graft. An admission Braden Observation assessment completed by an RN dated February 18, 2024, at 12:15 PM, upon the resident's readmission to the facility, revealed that the resident scored 15 indicating that the resident was at risk for pressure ulcers. A review of record entitled Skin Check dated February 19, 2024, at 3:34 PM revealed that a skin check was performed and there was a new skin issue. The resident's right heel had a purple area measuring 1.5 centimeters (cm) x 1.5 cm. The facility's noted immediate intervention was to apply skin prep every shift to the right heel. A review of record entitled Skin Check dated February 24, 2024, at 11:16 AM revealed that a skin check was performed and there were no new skin issues noted. A review of record entitled Skin Check dated February 27, 2024, at 11:44 AM revealed that a skin check was performed and there was a new skin issue found. Staff noted that the resident had an unstageable pressure ulcer (full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green or brown) and or eschar (tan, brown or black) in the wound bed) measuring 12.0 cm x 6.5 cm x 0.1 cm on the right and left buttocks. The immediate interventions were to cleanse with NSS (normal saline solution) and apply Santyl and boarder foam dressing daily and as needed. A review of the resident's care plan dated February 28, 2024, identified that the resident had an in house acquired open pressure ulcer to the buttocks related to immobility. The facility's planned interventions were to administer treatments and follow the facility's policies and procedures for the prevention and treatment of skin breakdown, pressure relieving device to chair and specialty mattress to bed. An observation on February 28, 2024, at 1:30 PM, revealed that the resident had an unstageable pressure ulcer located on the resident's right and left buttocks measuring 12.0 cm x 6.5 x 0.1 cm. The pressure sore appeared to have a small amount of slough (dead tissue usually yellow in color) on the wound bed, and the skin surround the wound was within normal limits. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility failed to demonstrate prompt implementation of interventions planned to prevent skin breakdown, prevent worsening and promote healing of pressure sores. The resident developed a DTI and an unstageable pressure ulcer. Following pressure sore development, there was no documented evidence that the facility implemented a turning and repositioning schedule and other preventative measures as outlined the facility's policy on Skin Integrity. During an interview with the Director of Nursing (DON) on February 28, 2024, at 2:20 PM, confirmed that the facility was unable to demonstrate the consistent implementation of measures planned to prevent pressure ulcers for residents at risk for skin breakdown and to promote healing and prevent worsening of pressure sores. 28 Pa. Code: 211.12 (c)(d)(1)(3)(5) Nursing Services 28 Pa. Code 211.5(f) Medical Records 28 Pa. Code 211.10 (a)(d) Resident care policies

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41460 Based on a review of select facility policy and clinical records and staff interview, it was determined that the facility failed to administer pain medication as prescribed by the physician and attempt non-pharmacological interventions to alleviate pain prior to the administration of pain medication prescribed on an as needed basis for one of six residents reviewed (Resident D2). Findings include: A review of the facility policy entitled Pain Management Program dated October 24, 2022, indicated that the facility shall provide adequate management of pain to ensure that residents attain or maintain the highest practicable physical, mental, and psychosocial well-being. Residents will be evaluated for pain upon admission, during periodic scheduled assessments, and with change in condition or status (e.g., after a fall, with change in behavior or mental status). If the resident's pain is not controlled by the current treatment regimen, the practitioner should be notified. The interdisciplinary team and the resident collaborate to arrive at pertinent, realistic and measurable goals for treatment. Review of Resident D2's clinical record revealed that the resident was readmitted to the facility on [DATE], following a hospitalization , with diagnoses to include fracture of lower end of left femur (hip), rheumatoid arthritis (chronic progressive disease causing inflammation in the joints and resulting in painful deformity, and immobility, especially in the fingers, wrists, feet, and ankles), dislocation of left kneecap, and contracture (a condition of shortening and hardening of muscles, tendons, or other tissue, often leading to deformity and rigidity of joints) of right lower extremity. Review of a significant change MDS assessment dated [DATE], revealed that the resident received a scheduled pain medication regimen and received PRN (as needed) pain medications. The MDS noted that the resident did receive non-medication intervention for pain in the last 5 days. The resident stated that she frequently experienced pain or hurting in the last 5 days which occasionally made it hard for her to sleep at night, and frequently limited her ability to participate in therapy sessions. and verbalized her pain was severe. Review of current physician orders revealed an order dated February 8, 2024, for Morphine Sulfate (a narcotic opioid pain medication used to treat severe ongoing pain) 15 mg orally three times a day for pain related to hip fracture, rheumatoid arthritis, and pain related to dislocated knee cap. The resident had additional orders for Oxycodone (narcotic opioid pain medication) 5 mg every 4 hours as needed for moderate pain (4-5), Tramadol (opioid pain medication used to treat moderate to severe pain) 50 mg every 4 hours as needed for chronic pain, and Tylenol 325 mg two tablets every 6 hours as needed for mild pain (1-3). (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident D2's Medication Administration Record (MAR) dated February 2024 revealed that staff administered Morphine Sulfate 15 mg three times a day as ordered at 6 AM, 2 PM, and 10 PM. Staff also administered Oxycodone 5 mg, as needed, on February 9, 2024, for pain levels of 7 and 8 (severe pain), on February 10, 2024, twice, for a pain level of 7, and on February 12, 13, 14, and 15 2024, the medication was administered for pain levels of 7 and 8 (severe pain). On February 17, 2024, at 4:49 PM Oxycodone 5 mg was administered for a pain level of 6 (moderate pain). According to documentation on the resident's MAR, the medication was ineffective for pain relief. There was no evidence that the facility attempted and/or provided non-pharmacological interventions in an attempt to reduce the resident's pain that was not relieved by prescribed opioid pain medication. There was no evidence that the physician was made aware that Resident D2's current pain regimen was not effective for pain control. The resident's February 2024 MAR revealed that Tramadol 50 mg as needed was administered on February 9, 2024, at 11:40 AM, on February 12, 2024, at 8:01 PM, and on February 21, 2024, at 4:05 PM for complaints of moderate pain, which was ineffective. There was no evidence that the physician was made aware that Resident D2's current pain regimen was not effective for pain control. Interview with the Director of Nursing on February 28, 2024, at approximately 1:30 PM confirmed facility failed to provide effective pain management and administer pain medication as per physician orders, consistently attempt non-pharmacological interventions to alleviate pain and follow facility policy for notification of the practitioner. 28 Pa. Code 211.12 (d)(1)(3)(5) Nursing Services 28 Pa. Code 211.10 (c)(d) Resident care policies