STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395260	A. Building B. Wing	09/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Carbondale Nursing and Rehabilitation Center	10 Hart Place Carbondale, PA 18407

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** 26142 Based on a review of clinical records, select facility reports and staff interview it was determined the facility failed to investigate the origin and promote the healing of a pressure sore for one of six residents sampled (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. A review of the clinical record revealed that Resident 1 was admitted to the facility on [DATE], with diagnoses to include weakness, history of falling at home, lumbar radiculopathy (pinched nerve) and dementia (a condition in which a person loses the ability to think, remember, learn, make decisions, and solve problems). A review of an admission Minimum Data Set assessment dated [DATE], (MDS - a federally mandated standardized assessment process completed periodically to plan resident care) revealed the resident had a Brief Interview for Mental Status score of 7 (BIMS is a structured evaluation aimed at evaluating aspects of cognition in elderly pateints score of 0 to 7 indicates severe cognitive impairment), and required assistance of staff for activities of daily living. Initial nursing notes as well as an admission nursing assessment dated [DATE] indicated the resident did not have skin impairment on her lower extremities. (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	Nursing documentation dated August 4, 2024 at 7:57 PM indicated Resident 1 was noted to have a blister (painful skin condition where fluid fills a space between layers of skin caused by rubbing surfaces together) to the left medial (inner side) of her heel. The blister was noted to be flat and intact with redness. There was no complaint of pain or discomfort. The area was cleansed with soap and water and optifoam (an absorbent, adhesive, foam dressing that absorbs force and friction) was applied. A physician order to cleanse the left medial heel with soap and water, apply Optifoam dressing every other day and consult for wound therapy, was implemented. A review of a care plan initiated July 19, 2024 and updated August 16, 2024 revealed the resident was at risk for potential/actual impairment of skin integrity due to previous intact blister on the medial left heel. The planned interventions were for nursing staff to elevate the resident's heels when in she is in bed. Nursing staff were to identify and document the potential causative factors and eliminate or resolve the area when possible. Nursing staff were to complete weekly treatment documentation to include a measurement of each area of skin breakdown to include width, length, depth, type of tissue, exudate and any other notable changes or observations. Complete wound treatment as ordered. A review of a facility skin integrity report dated August 4, 2024. completed by Employee 1 (LPN). indicated Resident 1 had an intact blister on her left heel measuring 4 cm x 4 cm. The form did not include the measurement or stage (progression of a pressure area) of the area, the area on the form for this information was blacked out with no documented entry. Nursing documentation dated August 6, 2024 at 1:11 P.M. indicated Resident 1 had a change of condition regarding the blister on her left heel. Current clinical findings revealed the resident is alert with confusion noted and denies pain or discomfort in her left heel area. A flat blister measuring 4 cm x 4 cm x 0 cm was present to her left heel. Nursing staff encouraged the resident to leave her shoe off to prevent pressure to that area. The resident's feet are to be elevated on pillow when she is in her bed. A review of a physician wound evaluation and management summery dated August 8, 2024 revealed, the resident had a venous wound (open, non-healing wounds that occur on the legs or ankles due to poor blood circulation. They are caused by blood pooling in the veins, which increases pressure and fluid in the affected area. Venous ulcers are often painful, red, and covered with yellow, fibrous tissue). An examination of the left medial heel revealed a fluid filled blister measuring 4 cm x 5 cm. The treatment plan included apply skin prep once daily for 30 days and to off load her heels when in bed. Factors complicating wound healing to include, polyneuropathy (a condition where multiple peripheral nerves become damaged. It can cause symptoms such as pain, decreased sensation, and weakness), muscle weakness and dementia. There was no evidence at the time of the survey, regarding peripheral venous issues with this resident. There was no evidence at the time of the survey that an investigation was completed into the development of Resident 1's left medial heel fluid filled blister on August 4, 2024. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview September 24, 2024 at approximately 3:00 PM, the resident's daughter stated her family visited Resident 1 on a daily basis. She stated on August 4, 2024 she visited the resident and saw a sign posted on the residents closet door stating, Do not put shoes on Resident 1, until OK given by Employee 2, RN. She stated she filed a grievance with the facility regarding her mother's blister. She stated when she saw the sign, the family looked at her heel and discovered the blister. She stated the sign on the closet door had a date of July 31, 2024 and indicated she was not informed as to why the sign was posted, or how long the resident had the skin issue on her heel. The facility never provided any information to the family as to how the blister developed or if it was caused by wearing her shoes. A review of the grievance report dated August 5, 2024 indicated the family was concerned with the blister on the resident's heel. There was no resolution to this grievance. Employee 2 the RN indicated she discussed the resident's condition with the family however, there was no documented evidence the blister was discussed. Interview with the director of nursing (DON) on September 24, 2024, at approximately 12:00 PM indicated Employee 1, LPN and Employee 2, RN did not investigate the blister on Resident 1's heel because they determined the area was a venous wound. She could not provide supporting evidence or any collaboration with the physician to support the diagnosis of venous insufficiency. 28 Pa. Code 211.12 (d) (5) Nursing services.

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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** 26142 Based on review of clinical records and staff and family interview, it was determined the facility failed to consistently monitor resident weights to timely identify and act upon a resident's weight loss, and implement necessary nutritional support to promote acceptable nutritional parameters for one resident out of 6 sampled (Resident 1). Findings include: A review of Resident 1's clinical record revealed the resident was admitted to the facility on [DATE], with diagnoses to include, lumbar radiculopathy (severe pain that radiates from the back into the hip and outer side of the leg caused by compression of a nerve), dementia (condition in which a person loses the ability to think, remember, learn, make decisions, and solve problems) and a history of falling. A review of an admission Minimum Data Set assessment dated [DATE], (MDS - a federally mandated standardized assessment process completed periodically to plan resident care) revealed the resident had a Brief Interview for Mental Status score of 7 (BIMS score is a structured evaluation aimed at evaluating aspects of cognition in elderly patients a score of 0 to 7 indicates severe cognitive impairment), and required assistance of staff for activities of daily living including set up assistance for meals. The resident was able to independently feed herself. A review of an admission physician order dated July 19, 2024 revealed the resident was to receive a regular diet with regular consistency and thin liquids. A review of her meal intakes dated July 19,2024 through August 8, 2024 indicated the resident consumed between 70% to 100% of her meals on most days. A review of Resident 1's weights revealed: July 19, 2024-185.8 pounds July 21, 2024-184.6 pounds August 1, 2024-184.6 pounds August 8, 2024-176.5 pounds From August 1 through August 8, 2024 Resident 1 lost 8.1 pounds which is a 4.39 % weight loss in one week. There was no evidence of reweights on or after August 8, 2024 to confirm the validity of the initial weight. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of nursing documentation revealed there was no communication/notification at the time the weight was obtained on August 8, 2024, between nursing or the physician regarding the residents weight loss. A review of a dietary/nutrition note dated August 14, 2024 at 1:49 PM revealed, the Registered Dietitian (RD) reviewed the resident's weights. The current weight was 176.5 pounds on August 8, 2024, the previous weight from August 1, 2024 was 184.6 pounds, indicative of a significant weight loss of 8.1 pounds or 4.4% over one week. The RD indicates the resident meal consumption are between 75% and 100%. The resident is encouraged to consume all meals and offer alternatives when meal intake is poor. This RD evaluation note was written six days after the significant weight loss was identified. There was no documented evidence at the time of the survey the physcian was notified of the significant weight loss. There were no additional interventions such as reweights after the weight loss was identified. Interview with the Director of Nursing on September 24, 2024, at 12 PM confirmed the facility was unable to demonstrate timely response to the resident's weight loss. 28 Pa Code 211.12 (d)(3)(5) Nursing services.