STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395298	A. Building B. Wing	08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lakewood Rehabilitation & Healthcare Center	147 Old Newport Street Nanticoke, PA 18634

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21738 Based on observations, review of clinical records, and resident and staff interview, it was determined the facility failed to provide reasonable accommodation of the needs of a resident with sensitive skin for one of 24 residents reviewed (Resident 94). Findings include: A review of the clinical record revealed that Resident 94 was admitted to the facility on [DATE], with diagnoses to include Crohn's disease (chronic inflammatory bowel disease that affects the lining of the digestive tract which can result in diarrhea and bloody stool). During an interview with Resident 94, a cognitively intact resident, on August 29, 2024, at 9:10 AM, the resident stated she has a problem with diaper rash and that her skin is easily irritated due to her diagnosis of Crohn's disease. Resident 94 further stated she does have episodes of fecal incontinence and when staff are cleaning her with a washcloth after a bowel movement it feels like her skin is ripping. Resident 94 stated that disposable cloths are so much nicer, cleaner, and more helpful to her but the facility does not provide them. The resident expressed she would be willing to purchase the disposable hygeine wipes to aide in her comfort however the facility does not want them to be used in the facility. Observation of the linen closet on the East Nursing Unit on August 29, 2024, at 9:15 AM revealed that the washcloths on the shelf were stiff and not soft to the touch. During an interview with the Nursing Home Administrator (NHA) on August 29, 2024, at 1:00 PM the NHA confirmed the facility does not use disposable hygiene wipes. The NHA noted that in the past (greater than a year ago) when wipes were being used the facility septic system became clogged and the decision was made to no longer use disposable hygiene wipes. At the time of the conclusion of the survey on August 30, 2024, the facility was unable to provide a resolution for Resident 94's request to have disposable hygiene wipes or at least soft washcloths to ensure the resident did not experience discomfort when being changed after incontinent episodes and during perineal (practice of washing the genital and rectal areas to prevent infection, irritation, and odors) care. 28 Pa. Code 204.14 Supplies

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48277 Based on review of clinical records and staff interviews, it was determined the facility failed to timely consult with the resident's physician regarding the need to initiate a new treatment for one resident out of 24 sampled (Resident 72). Findings include: A review of Resident 72's clinical record revealed the resident was admitted to the facility on [DATE], with diagnoses to include complete traumatic amputation at the knee level of the left lower leg, and abnormalities of gait and mobility. The resident had a physician order dated July 17, 2024, for nursing staff to cleanse his left BKA (below the knee amputation) with NSS (normal saline solution), pat dry, apply TAO (triple antibiotic ointment) to the open wound followed by application of a 4x4 (gauze pad), kerlix (gauze roll), and ace bandage every evening shift for wound care. A review of the resident's Report of Consultation form dated August 12, 2024, signed by the CRNP (certified registered nurse practitioner) from the Vascular Surgeon's office stated that resident 72's left BKA wound was improving and to continue wound care. Refer to the Prosthetic company (company that provides prosthetic [artificial leg] devices), ok for stump shrinker (a compression garment that is used to reduce the amount of fluid or swelling in the limb and shape the residual limb after an amputation so that it becomes a more ideal shape and size to fit into a prosthesis). A review of the resident's Report of Consultation form dated August 21, 2024, signed by the CPO (certified prosthetist/orthotist) from the Prosthetic Clinic stated the resident was fitted with a left stump shrinker to be worn as tolerated. The device can be removed at night if needed. Goal is to wear the shrinker 23 hours per day. Resident was to return in 2 weeks for possible casting. Will only proceed with casting if the wound is healed. Further review of Resident 72's physician orders revealed the resident did not have an order to wear the stump shrinker as recommended by the prosthetist on August 21, 2024, in order to reduce the edema and shape of the left lower extremity so it will properly fit into a prosthesis. Interview with the Employee 5 (Physician Assistant) on August 29, 2024, at 9:50 AM revealed she was unable to recall if the facility notified her of Resident 72's results from his appointment with the the Prosthetic Clinic. She confirmed there was no physician's order for the resident to wear a stump shrinker as recommended by the prosthetist on August 21, 2024. There was no documented evidence the physician was timely notified of the resident's consultation with the prosthetist at the Clinic on August 21, 2024, and the recommendations to wear the stump shrinker up to 23 hours per day in preparation to be fitted for a prosthesis. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the Director of Nursing on August 29, 2024, at approximately 10:00 AM confirmed the facility failed to timely notify the physician of the prosthetist recommendation for the application and wear schedule of Resident 72's stump shrinker. 28 Pa Code 211.12 (d)(3)(5) Nursing services

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep residents' personal and medical records private and confidential. 26142 Based on observations and staff interviews, it was determined the facility failed to maintain residents right to privacy and confidentiality during a physician visit for 7 residents and failed to ensure personal privacy for one resident (Resident 78) by placing health care instructions in a place compromising the resident's privacy. Findings include: During an observation August 27, 2024 at 10 AM, seven residents were seated in wheelchairs in the resident lounge (located in the hallway between the 2 nurses stations) and one resident seated a wheelchair in the hallway, outside of the lounge. The contracted eye doctor was examining an additional resident at a table in the room. There was no screen or partition separating the Physician and the resident being examined from being seen by the residents in the room waiting to be seen or the residents, staff and visitors in the hallway outside of the activity room. The doors to the room were open and the walls were glass, allowing the activities inside the room to be viewed from the hallway. There was no activity at the time of the observation for the residents to participate in while waiting for their eye examinations due to the physician visit in this activity room. An interview at the time of the observation with the Nursing Home Administrator (NHA) confirmed the residents' dignity was compromised by allowing the residents to be viewed by others while being examined by the physician. The physician failed to ensure residents personal privacy was maintained during the visit. An observation August 30, 2024 at approximately 12 PM revealed a sign posted on the wall of Resident 78's room located across from her bed which revealed instructions from the therapy department regarding the use of assistive devices to be utilized by the resident to be used while the resident was in bed. During an interview August 29, 2024 at 2 PM, the interim DON (director of nursing) confirmed that Resident 78's therapy instructions should not be posted on her wall. During an interview on August 29, 2024, at 2 PM the nursing home administrator (NHA) confirmed the facility staff is responsible for addressing the needs of residents in a manner that promotes each resident's quality of life and assures that each residents privacy is protected. The NHA confirmed that Physician examinations are to be conducted in private. 28 Pa. Code 201.29(a) Resident Rights 28 Pa. Code 201.18 (e)(1) Management 28 Pa. Code 211.2 (d)(6) Medical director 28 Pa. Code 211.12 (c)(d)(1)(3) Nursing services

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48277 Based on clinical record review and staff interview it was determined the facility failed to develop a comprehensive person-centered plan of care to meet the individualized needs of one resident out 24 sampled (Resident 72). Findings include: Review of Resident 72's clinical record revealed the resident was admitted to the facility on [DATE], with diagnoses to include the presence of an automatic implantable cardiac defibrillator (AICD- is a microcomputer that is implanted under the skin of the upper chest area. It monitors heart rate and delivers therapy in the form of small electrical pulses. An AICD is a permanent device inserted into the right ventricle and typically placed near the collarbone under the skin of the chest) and complete traumatic amputation at the knee level of the left lower leg. A review of Resident 72's current comprehensive plan of care, conducted during the survey ending August 30, 2024, revealed there was no documented evidence the facility identified and addressed the resident's care needs related to the AICD device as an area of focus with interventions to provide AICD checks as ordered or to monitor for signs and symptoms of AICD complications. The facility failed to address the emergency care of the AICD device and actions to be taken if the AICD was activated (i.e., consulting the physician, obtaining vital signs [clinical measurements, specifically pulse rate, temperature, respiration rate, and blood pressure, that indicate the state of a patient's essential body functions] and keeping the resident and staff safe from the electrical shock. The resident should notify staff if a shock is felt, and staff should be aware not to touch resident is being shocked since the shock can be felt). Interview with Director of Nursing on August 29, 2024, at 9:50 AM confirmed the facility failed to fully address the care and management of Resident 72's AICD on the resident's person-centered plan of care. 28 Pa. Code 211.12 (c)(d)(3)(5) Nursing services.

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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** 48276 Based on a review of clinical records, select facility incident/accident reports, and staff interview it was determined the facility failed to timely implement effective safety interventions, including necessary staff supervision, at the level and frequency required, for a resident with known unsafe behaviors to prevent falls, including a fall with hip fracture for one resident out of the 24 sampled (Resident 91) and multiple falls for one out of the 24 sampled reviewed (Resident 33). Findings include: A review of the clinical record for Resident 91 revealed admission to the facility on [DATE], with a diagnosis to include dementia (a chronic or persistent disorder of the mental processes caused by brain disease or injury and marked by memory disorders, personality changes, and impaired reasoning), and abnormalities of gait and mobility (difficulty walking). A review of an admission MDS (Minimum Data Set - a federally mandated standardized assessment conducted at specific intervals to plan resident care) dated July 29, 2024, revealed Resident 91 was severely cognitively impaired with a BIMS score of 0 (BIMS- Brief Interview for Mental Status is a tool to screen and identify the cognitive condition of long-term care residents). A score of 0-7 represents severe cognitive impairment), and she required substantial/maximal assistance of staff for activities of daily living. A review of a care plan dated July 25, 2024, revealed Resident 91 was at risk for falls related to impaired cognition with decreased safety awareness. Planned interventions included: alarm to bed and wheelchair, fall mats when in bed, implement preventative fall interventions/devices, maintain call light within reach, educate resident to use call light, maintain needed items within reach, and monitor for changes in mobility. A review of nursing documentation dated July 24, 2024, at 5:54 PM revealed Resident 91 was not cooperative with staff on the day of admission, not allowing staff to complete a body audit and clinging to the transport person, refusing to let him go. She was noted to be walking up the hallway without assistance, grabbing onto the side rails. Safety alarms were added to her wheelchair that sounded to alert staff of any unsafe movements. Nursing documentation dated July 26, 2024, at 7:29 AM revealed the resident pulled out her Foley catheter (a thin flexible tube inserted into the bladder that then drains the urine into a collection bag) and that she was trying to exit the building via doors and windows. The resident was placed on 1:1 (one-to-one supervision - one staff member is assigned to provide observation and assistance to one resident who is not to be left unattended at any time). Nursing documentation dated July 26, 2024, at 6:05 PM indicated Resident 91 continued to exhibit exit seeking behaviors with agitation and attempts at physical aggression. The physician was contacted, and the resident remained on 1:1 supervision while she remained awake. (continued on next page)

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	395298	A. Building B. Wing	08/30/2024

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A physician's order dated July 26, 2024, revealed an order for 1:1 supervision while awake, every shift due to her exit seeking behaviors. Nursing documentation dated July 31, 2024, at 5:53 AM revealed Resident 91's bed alarm was sounding, and Resident 91 was observed sitting on the floor in her room across from the bathroom door. She was noted to be incontinent of urine at that time. The planned intervention was to continue watching the resident on 1:1 while she was awake. The resident was brought to the nurses station for close supervision. The resident made multiple attempts to stand up from her wheelchair and it was noted she was difficult to redirect. The resident assisted to bed at 5:30 AM after she utilized the bathroom. Nursing documentation dated August 2, 2024, at 5:39 AM revealed Resident 91 was on the floor of her bathroom, lying on her right side. Her bed alarm was sounding at the time of the fall. The resident stated, I got up to go to the bathroom. The resident was noted to have a 6 cm x 5 cm bruise to the right upper arm and a 2 cm x 3 cm bruise to her right inner wrist. The nurse assessed the resident, and the physician was notified. The resident was placed near the nurses station for close observation. Nursing documentation dated August 4, 2024, at 5:00 AM revealed Resident 91 was awake most of the night and remained at the nurse's station for close supervision. As noted she continues to attempt to stand and self-transfer and staff were unable to redirect her to ensure her safety. Nursing documentation dated August 7, 2024, at 3:00 AM indicated Resident 91 was found on the floor on the right side of her bed. A planned intervention to place fall mats next to her bed was put into place to prevent injury from future falls from her bed. Nursing documentation dated August 7, 2024, at 4:45 PM noted the resident stood up from her wheelchair and fell to the ground. She did not sustain any injuries at that time. A physician's order dated August 7, 2024, revealed the 1:1 supervision order had been discontinued. Nursing documentation August 8, 2024, at 8:25 AM revealed that Resident 91 was continually roaming the building (in her wheelchair), exit seeking, self-transferring, and unable to be redirected. She was found lying on the bench outside of the facility chapel (located in the front of the facility away from resident areas). She was returned to the nurses station. Nursing documentation dated August 13, 2024, at 11:00 AM revealed Resident 91 was observed lying on her back on the floor in room [ROOM NUMBER] (Resident 91 resides in room [ROOM NUMBER]-A). A full body assessment was completed. The resident was complaining of right hip pain. The physician was contacted, and an X-ray of the pelvis was ordered. A review of the X-ray report dated on August 13, 2024, revealed an acute right intertrochanteric hip fracture (fracture of the right hip). The resident was admitted to the hospital on August 14, 2024, and had surgical repair of her right hip on August 15, 2024. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	At the time of the survey ending August 30, 2024, the facility was unable to provide documented evidence that physician ordered 1:1 supervision was provided to Resident 91 as planned. The timeframe for 1:1 supervision was July 26, 2024 to August 7, 2024. The facility failed to repeatedly provide effective safety interventions and sufficient and timely staff supervision, at the level and frequency required, to prevent multiple falls for a resident at risk for falls, with known unsafe behaviors and a history of falls, resulting in a fall with major injury. An interview with the Nursing Home Administrator on August 30, 2024, at 8:00 AM confirmed the facility failed to provide effective safety interventions and sufficient and timely staff supervision to Resident 91 to prevent repeated falls with a major injury. A clinical record review revealed Resident 33 was admitted to the facility on [DATE], with diagnoses that include 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). A review of an admission MDS assessment dated [DATE], revealed that Resident 33 is severely cognitively impaired with a BIMS score of 03 (a score of 01-07 indicates severe impairment). A review of Resident 33's care plan, initiated on June 25, 2024, revealed she was at risk for falls due to a history of falls and impaired cognition with decreased safety awareness. Interventions to reduce this risk included a bed alarm, bed in the lowest position, wheelchair alarm, and non-skid footwear. A review of facility incident reports from June 25, 2024, to August 26, 2024 revealed Resident 33 sustained 9 unwitnessed falls. The incidents were as follows; June 25, 2024, at 6:30 PM: Resident 33 was found on the floor; no injuries were noted. Planned interventions indicated bed and chair alarms were added for resident safety. July 2, 2024, at 12:25 PM: The resident was found crawling out of her bedroom; no injuries were noted. New interventions: neurological checks, therapy screening, psychiatric care consult, care plan review. July 8, 2024, at 8:26 AM: Resident found on the floor, on hands and knees; no injuries were noted. New interventions: neurological checks, therapy screen, resident education, nursing interventions, care plan review. July 8, 2024, at 10:03 PM: Resident found on the floor with a skin tear on her knees. Pain level two out of 10 (minimal pain). Physician notified, and treatment ordered. New interventions: psychiatric care consult, monitoring for infection, care plan review. July 15, 2024, at 11:14 AM: Resident found sitting on the floor next to her wheelchair with the alarm sounding; no injuries were noted. The resident reported she had left cheek and shoulder pain. (continued on next page)

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	395298	A. Building B. Wing	08/30/2024

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F 0689 Level of Harm - Actual harm Residents Affected - Few	July 17, 2024, at 1:30 PM: Resident found lying on the floor in the east long hall; no injuries were noted. New interventions: neurological checks, therapy screen, social service support, care plan review. August 5, 2024, at 2:23 PM: Resident found on the floor; no injuries noted. New interventions: neurological checks, therapy screen, social service support, psychiatric care consult, care plan review. August 14, 2024, at 3:46 PM: Resident found sitting on buttocks with alarm sounding; no injuries noted. New interventions: neurological checks, therapy screen, social service support, psychiatric care consult, care plan review. August 26, 2024, at 3:31 PM: Resident found sitting on the floor with open purpura (small blood vessels leak blood under the skin) noted. Physician and resident representative notified. New interventions: treatment as ordered, neurological checks, therapy screen, social service support, psychiatric care consult, care plan review. The resident's care planned interventions proved ineffective in preventing multiple falls. The interventions were not changed to prevent falls, the facility's planned interventions implemented were in response to the falls such as neurological checks, therapy screens a review of care plans. The facility did not develop and implement measures to increase staff supervision and staff monitoring of the resident and the resident's activities to determine the cause of the falls and plans to prevent falls. During an interview on August 30, 2024, at approximately 11:30 AM, the Director of Nursing (DON) confirmed that Resident 33 had multiple unwitnessed falls and the facility's interventions and supervision have not been effective. The DON acknowledged the facility is responsible for providing adequate supervision to prevent resident falls. 28 Pa Code 211.12 (d)(3)(5) Nursing services

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	395298	A. Building B. Wing	08/30/2024

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26142 Based on review of select facility policy and clinical records, and staff interview, it was determined the facility failed to conduct a timely bladder assessment and develop and implement an individualized plan to meet the resident's toileting needs, including timely staff assistance with toileting and incontinence management and justification for the continued use of an indwelling catheter for two residents out of 24 sampled residents (Resident 91 and 32). Findings include: A review of the facility policy titled Urinary Continence and Incontinence - Assessment and Management last reviewed by the facility on July 1, 2024, revealed the staff and practitioner will appropriately screen for, and manage, individuals with urinary incontinence, manage incontinence following relevant clinical guidelines, provide appropriate services and treatment to help residents restore or improve bladder function, and prevent urinary tract infections to the extent possible. Residents will be assessed for information related to urinary incontinence with staff defining each individual's level of continence, referring to the criteria in the Minimum Data Set (MDS). Nursing staff will seek and document details related to continence to include: voiding patterns, associated pain or discomfort, and types of incontinence (stress, urge, mixed, overflow, transient and functional). If the individual remains incontinent despite treating transient causes of incontinence, the staff will initiate a toileting plan. Staff will document the result of the toileting trail in the resident's medical record. If the resident responds well, the toileting program will be continued. If the resident does not respond and does not try to toilet, staff will use a check and change strategy. A check and change strategy involves checking the resident's continence status at regular intervals and using incontinence devices or garments. The primary goals are to maintain dignity and comfort and to protect the skin. A review of the clinical record for Resident 91 revealed admission to the facility on [DATE], with diagnosis to include dementia (a chronic or persistent disorder of the mental processes caused by brain disease or injury and marked by memory disorders, personality changes, and impaired reasoning), urinary tract infection, abnormalities of gait and mobility (difficulty walking), and need for assistance with personal care. Review of Resident 91's Admission/Readmission Evaluation dated July 24, 2024, revealed the resident was admitted to the facility with a Foley catheter (a thin flexible tube inserted into the bladder which then drains the urine into a collection bag) and that she was at a high risk for falling. A review of nursing documentation dated July 26, 2024, at 7:29 AM revealed the resident pulled out her Foley catheter and she was trying to exit the building via doors and windows. Resident placed on 1:1 (one-to-one supervision - one staff member is assigned to provide observation and assistance to one resident who is not to be left unattended at any time). A nurses note dated July 26, 2024, at 11:40 PM revealed the physician was aware the resident pulled out her foley and the physician said it needed to be placed back in. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395298	A. Building B. Wing	08/30/2024

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A nurses note dated July 28, 2024, at 1:23 PM revealed the physician was made aware that Resident 91 was combative when attempted to reinsert the foley catheter. Physician made aware the resident was voiding QS (quantity sufficient) on each shift and without difficulty. Per physician note/order- ok to discontinue Foley catheter as long as the resident is voiding without difficulty. Will continue to monitor output every shift. A review of an admission MDS (Minimum Data Set - a federally mandated standardized assessment conducted at specific intervals to plan resident care) dated July 29, 2024, revealed Resident 91 was severely cognitively impaired with a BIMS score of 0 (BIMS- Brief Interview for Mental Status is a tool to screen and identify the cognitive condition of long-term care residents. A score of 0-7 represents severe cognitive impairment). Continued review revealed she required substantial/maximal assistance of staff for toileting, toilet transfers, was frequently incontinent of urine, and was not on a toileting program. Nursing documentation dated July 31, 2024, at 5:53 AM, revealed Resident 91's bed alarm was sounding, and Resident 91 was observed sitting on the floor in her room across from the bathroom door. She was noted to be incontinent of urine at that time. Documention further indicated continue on 1:1 while resident is awake. Brought to nurses station for close supervision with multiple attempts to stand, difficulty at times to redirect. Resident assisted to bed at 5:30 AM after she utilized the bathroom. A nurses note dated August 2, 2024, at 5:39 AM, revealed that Resident 91 was on the floor of her bathroom, lying on her right side. Her bed alarm was sounding at the time of the fall. The resident stated, I got up to go to the bathroom. The resident was noted to have a 6 cm x 5 cm bruise to the right upper arm and a 2 cm x 3 cm bruise to the right inner wrist. The nurse assessed the resident, and the physician was notified. The resident was placed near the nurses station. A review of a care plan dated August 2, 2024, revealed Resident 91 had episodes of bladder and bowel incontinence due to diuretic use and urinary tract infection (UTI) with interventions to include: assist with toileting needs, monitor for signs/symptoms of UTI, monitor peri-area for redness/irritation, provide peri-care after each incontinent episode, apply house barrier cream, and report if no urine output. The care plan failed to identify an incontinence management schedule or a scheduled toileting program to manage Resident 91's incontinence. Further review of Resident 91's clinical record revealed that it was not until August 4, 2024, 9 days after the self-removal of the foley catheter, that the facility performed a bowel and bladder assessment on Resident 91. There was no evidence at the time of the survey ending August 30, 2024, that a bladder assessment was completed timely after the self-removal of the Foley catheter on July 26, 2024, and that a scheduled toileting program was developed and implemented in an attempt to maintain bladder function as an intervention for this resident with repeated falls attempting to use the bathroom. Clinical record review revealed Resident 32 was admitted to the facility on [DATE] with diagnosis to include, aftercare, therapy services post surgical repair of right hip. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395298	A. Building B. Wing	08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lakewood Rehabilitation & Healthcare Center	147 Old Newport Street Nanticoke, PA 18634

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An admission MDS assessment dated [DATE] revealed the resident to be cognitively intact with a BIMS score of 13 (12 to 15 indicates cognitively intact) required staff assistance for activities of daily living and had an indwelling Foley catheter. A review of a care plan dated July 30, 2024 reveled, Resident 32 is at risk for impaired skin integrity related to pain, uses devices that can cause pressure: indwelling catheter tubing. There were no noted interventions related to the residents indwelling Foley catheter on the residents care plan. There was no mention of the Foley catheter use or care and services related to the device in the resident's care plan. A nursing Note dated August 19, 2024 1:59 P.M. revealed, Per the Physician, may discontinue the resident's Foley catheter for a voiding trial. Obtain a bladder scan (an ultrasound is a test that uses sound waves, a test is used for bladder issues, the amount of urine remaining in the bladder after voiding) every shift for three days. Re-insert foley catheter for greater than 400 cc's post residual volume (amount of urine left in the bladder after voiding). A nursing Note August 20, 2024 at 1:46 PM the resident's bladder scan revealed 60 cc's of urine in the bladder after the Foley catheter was removed. The resident was incontinent of urine twice during the shift. There was no additional documentation at the time of the survey regarding any additional bladder scanning. Nursing documentation revealed that a bladder assessment was completed on August 24, 2024 noting that Resident 32 was a potential candidate for scheduled toileting. There was no additional documentation regarding the bladder assessment including a voiding trial, identification of the type of incontinence or the implementation of a toileting plan. There was no justification for the use of the Foley catheter upon admission to the facility and no justification for the delay in removal of same and the delay in urinary assessment for Resident 32. Interview with the Nursing Home Administrator on August 30, 2024, at 8:00 AM was unable to provide evidence the facility conducted a timely bladder assessment of Resident 91 and the facility had developed and implemented a plan to address the resident's toileting needs after the self-removal of the foley catheter. She further confirmed there was no documented justification for the use of the Foley catheter, delay in removal or lack of a thorough assessment for Resident 32. 28 Pa. Code 211.12 (d)(1)(3)(5) Nursing services 28 Pa. Code 211.10(a)(d) Resident care policies

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	395298	A. Building B. Wing	08/30/2024

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26142 Based on clinical record and select facility policy review, and staff interview it was revealed the facility failed to monitor weight as planned to ensure acceptable parameters of nutritional status are maintained to the extent possible for two of 24 residents sampled (Residents 27 and 78) and failed to ensure a physician ordered fluid restriction was maintained for one of 24 sampled residents (Resident 25). Findings include: Review of facility policy entitled Weight Assessment and Intervention, last reviewed by the facility on July 1, 2024, indicated that resident weights are monitored for undesirable or unintended weight loss or gain. Residents are weighed upon admission and at intervals established by the interdisciplinary team. Any weight change of 5-percent or more since the last weight assessment is obtained the next day for confirmation. If the weight is verified, nursing will immediately notify the dietitian in writing. Unless notified of significant weight change, the dietitian will review the weight record monthly to follow individual weight trends over time. The threshold for significant unplanned and undesired weight loss will be based on the following criteria as follows; 1 month (30 days) - 5% weight loss, 3 months (90 days) - 7.5% weight loss, and 6 months (180 days) - 10% weight loss. Undesirable weight change is evaluated by the treatment team whether or not the criteria for significant weight change has been met. The physician and the multidisciplinary team identify conditions and medications that may be causing anorexia, weight loss, or increasing the risk of weight loss. Care planning for weight loss shall address, to the extent possible, the identified causes of weights loss, goals and benchmark for improvement, and time frames and parameters for monitoring and reassessment. A review of the clinical record revealed that Resident 27 was admitted to the facility on [DATE], with diagnoses which included dementia (chronic or persistent disorder of the mental processes caused by brain disease or injury and marked by memory disorders, personality changes, and impaired reasoning) and diabetes. Resident 27's weight record revealed: February 9, 2024 129 pounds March 14, 2024 139 pounds April 18, 2024 132.6 pounds May 6, 2024 140.8 pounds June 17, 2024 127.2 pounds July 2, 2024 129.4 pounds July 9, 2024 129 pounds (continued on next page)

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	395298	A. Building B. Wing	08/30/2024

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	August 4, 2024 118.6 pounds (indicative of an 8% weight loss in 26 days) A nutrition note dated June 27, 2024, noted reviewed weights. Previously acknowledged weight change. Weight loss noted. Resident with a significant weight loss of 20 pounds or 13.7% in 90 days. Questioning accuracy of current weight. Recommend weekly weights times four weeks to monitor for accuracy and further significant change. Resident with history of weight fluctuations noted. Goal is weight stability or gradual weight gain. Further review of the clinical record revealed the weekly weight was obtained on July 2 and July 9, 2024. However, further review of the clinical record revealed no documented evidence the weekly weight for July 16, 2024 or July 23, 2024, was completed. The next documented weight was 118.6 pounds on August 4, 2024, which was indicative of an 8% weight loss in 26 days. A significant change nutrition noted dated August, 5, 2024, noted the Resident continues on a regular diet, regular texture, thin consistency of fluids. She continues with 26-100% meal intake and typically accept snacks. Most recent weight reflects a significant loss of 10.0 lbs or 7.8% in 30 days. The resident has normal BMI (body mass index-measure of weight relative to height used as a screening method to determine if a resident is underweight, overweight or obese) of 19.7 but underweight for age group. Resident admitted to hospice care on July 22, 2024, with dx of senile degeneration of brain (dementia). Recommend to discontinue weights for comfort measures. No edema. Nutrition interventions in place including nutritious juice twice daily, liquid protein once daily, and fortified mashed potatoes for additional nutritional support. Weight loss and decreased intake anticipated and unavoidable with end of life process. No reports of chewing or swallowing difficulty with current diet. Continue nutrition plan as ordered. Interview with the registered dietitian (RD) on August 29, 2024, at approximately 11:30 AM confirmed the intervention recommended on June 27, 2024, for weekly weights times four weeks was only completed for two weeks verses the recommended four weeks. The RD confirmed the facility failed to identify that the weekly weights were not completed as recommended to ensure that Resident 27's weight was timely monitored as recommended on June 27, 2024. Clinical record review revealed that Resident 78 was admitted to the facility on [DATE] with diagnosis to include dementia, muscle weakness, dysphagia (difficulty swallowing) and protein/calorie malnutrition. An annual MDS (Minimum Data Set - a federally mandated standardized assessment conducted at specific intervals to plan resident care) dated June 2, 2024 revealed the resident to be severly, cognitively impaired with a BIMS score of 2 (over 7 indicates severe cognitive impairment, BIMS stands for Brief Interview for Mental Status. The BIMS test is used to get a quick snapshot of how well you are functioning cognitively at the moment) A review of a care plan initiated June 12, 2023 and revised May 28, 2024 for at risk for altered nutritional status related to dementia, depression and a history of desirable planned weight gain expect weight gain fluctuations related to fluid status changes, edema. (continued on next page)

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	395298	A. Building B. Wing	08/30/2024

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interventions to include, Monitor meal percentage intake for changes in eating habits Periodically obtain resident's weight, evaluate, and report to RD, physician, and family of significant weight changes Provide nutritional supplement(s) as ordered by physician. A review of Resident 78's weights revealed; June 11, 2024 138.4 Lb July 3, 2024 136.0 Lbs August 4, 2024 114.7 Lbs The resident lost 21.3 pounds or 15.66% in 32 days. A review of a Nutrition Note dated August 13, 2024 at 10:51 AM revealed, Monthly weight obtained August 4, 2024, 114.7 lbs a 21 lb weight loss or 15.4% in 30 days. Prior weight history: June 11, 2024, 138.4 lbs, July 3, 2024, 136.0 lbs. The note further indicated Resident 78 has a significant weight loss due to poor/varied food intakes. Questioning validity of current weight. Recommend reweights to determine accuracy and obtain new baseline. Resident receiving regular diet, with 26-100% intake. Healthshake twice a day in place. Recommend increase healthshake three times a day. Registered Dietitian (RD) to follow up upon reweights obtained. Nutrition plan of correction reviewed. The prior nutrition note was dated June 25, 2024 at 10:56 AM indicating that Resident 78 had a small non significant weight gain at that time. The significant weight loss was noted on August 4, 2024. There was no evidence that nursing staff informed the RD or the Physician of the significant weight loss at the time of the weight. During an interview August 28, 2024 at approximately 11 AM, the RD stated she reviews the electronic clinical record for weight alerts for residents. She could not state why she was unaware of Resident 78's 21 pound weight loss on August 4, 2024. She stated that it could have been an inaccurate weight, however a reweights was never completed by nursing staff. A review of a facility policy for Encouraging and Restricting Fluids reviewed July 2024 revealed, The purpose of this procedure is to provide the resident with the amount of fluids necessary to maintain optimum health. This may include encouraging or restricting fluids. (continued on next page)

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	395298	A. Building B. Wing	08/30/2024

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The procedure to include, Record the amount of fluid consumed on the intake side of the intake and output record. Record the intake in mls (milliliters). The procedure stated the amount of fluids consumed by the resident during the shift should be documented. The reporting to include, Report other information in accordance with facility policy and professional standards of practice. Clinical record review revealed that Resident 25 was admitted to the facility on [DATE] with diagnosis to include diabetes and chronic kidney disease requiring dialysis. An annual MDS assessment dated [DATE] revealed Resident 25 to be severly cognitively impaired with a BIMS score of 7 (0 to 7 indicating severe cognitive impairment), received dialysis treatment and required assistance of staff for activities of daily living. A review of current Physicians orders initiated April 20, 2024 revealed a 1000cc fluid restriction: Nursing to provide: 120 cc's 7AM to 3 PM shift 120 cc' 3 PM to 11 PM shift 40 c's 11 PM to 7 AM shift Dietary to provide: 240 cc's breakfast 240 cc's lunch 240 cc's dinner meals A review of an August 2024 resident daily fluid intake, provided by nursing and on the resident meal trays (dietary intake) , revealed the following. The resident exceeded his allotment of fluids (1000 cc) for nursing and dietary department on the following dates: dietary intake nursing intake daily total August 18, 2024 800 cc's 840 cc's 1640 cc's August 19, 2024 1100 cc's 680 cc's 1780 cc's August 21, 2024 1000 cc's 360 cc's 1360 cc's August 22, 2024 100cc's 280 cc's 1330 cc's August 23, 2024 1100 cc's 240 cc's 1340 cc's August 24, 2024 800 cc's 360 cc's 1160 cc's (continued on next page)

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	395298	A. Building B. Wing	08/30/2024

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	August 25, 2025 900 cc's 360 cc's 1260 cc's August 26, 2024 850 cc's 280 cc's 1130 cc's August 27, 2024 1500 cc's 240 cc's 1740 cc's August 28, 2024 1000cc's 280 cc's 1280 cc's There was no evidence at the time of the survey that daily fluid totals were completed prior to the end of the survey and that the Registered Dietitian and the Physician were notified in regards to his fluid restriction. An interview August 29, 2024 at approximately 1 PM, the facility Registered Dietitian confirmed that Resident 25's fluid restriction was not calculated and she was unsure if he met or exceeded his fluid restrictions. She could not state of the resident's daily fluids were calculated. 28 Pa. Code 211.5 (f) Medical Records. 28 Pa. Code 211.12 (c)(d)(1)(3)(5) Nursing services.

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	395298	A. Building B. Wing	08/30/2024

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21738 Based on observation, clinical record, and staff interview it was determined the facility failed to ensure the resident received enteral feedings as prescribed for one resident receiving an enteral feeding out of two residents sampled (Resident 31). Findings include: Review of Resident 31's clinical record revealed the resident was admitted to the facility on [DATE], with diagnoses to include cerebral infarction (stroke) and dysphagia (difficulty swallowing). Resident 31 required a percutaneous endoscopic gastrostomy (PEG tube) also known as G-tube (gastrostomy tube is a medical procedure in which a tube is passed into the patient's stomach through the abdominal wall, most commonly to provide a means of feeding when oral intake is not adequate for enteral feeding [enteral nutrition generally refers to any method of feeding that uses the gastrointestinal (GI) tract to deliver part or all of a person's caloric requirements). Current physician orders initially dated July 12, 2024, noted an order for Glucerna 1.5, 50 cc/hour continuous until 1000 cc's infused (12:00 PM to 8:00 AM). Observations of the resident's tube feeding pump on August 29, 2024, at 8:55 AM, 9:15 AM, and 10:25 AM revealed the resident's tubefeeding pump was turned off. There was approximately 200 cc's of Glucerna 1.5 tubefeeding still remaining in the 1000 cc pre-filled container. Interview with employee 11 (LPN) on August 29, 2024, at approximately 10:30 AM confirmed she had turned off Resident 31's tubefeeding at 8:00 AM as per the direction on the resident's Medication Administration Record to turn the feeding off at 8:00 AM (despite approximately 200 cc's of tubefeeding remaining in the container). Interview with the registered dietitian (RD) on August 29, 2024, at approximately 11:00 AM confirmed the resident was to receive 1000 cc' s of Glucerna 1.5 tubefeeding daily between the hours of 12:00 PM and 8:00 AM. The RD confirmed that if for any reason the feeding is turned off or started late, the feeding should continue until 1000 cc's of tubefeeding is received to ensure the resident's nutritional needs are met and the physician order is followed. Interview with the corporate chief nursing officer on August 29, 2024, at approximately 1:30 PM failed to provide documented evidence that Resident 31's tubefeeding was administered as per physician order to ensure that 1000 cc's of tubefeeding was infused before the feeding pump was turned off on the morning of August 29, 2024. 28 Pa. Code 211.12 (d)(1)(5) Nursing services.

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	395298	A. Building B. Wing	08/30/2024

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F 0697 Level of Harm - 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** 48276 Based on a review of clinical records, observations, select facility policy, and staff, resident, and resident family interviews, it was determined the facility failed to implement pain management interventions and failed to recognize when the resident suffered pain without relief for one resident out of 24 sampled (Resident 260). Findings include: A review of the facility policy entitled Pain Assessment and Management, last reviewed by the facility on July 21, 2024, revealed the facility's pain management program is based on a facility-wide commitment to appropriate assessment and treatment of pain, based on professional standards of practice, the comprehensive care plan, and the resident's choices related to pain management. The policy indicates that pain management is a multidisciplinary care process that includes assessing the potential for pain, recognizing the presence of pain, developing and implementing approaches to pain management, and monitoring for the effectiveness of interventions. Also, the policy indicates that acute pain or significant worsening of chronic pain should be assessed every 30 to 60 minutes after the onset and reassessed as indicated until relief is obtained. A clinical record review revealed Resident 260 was admitted to the facility on [DATE], with diagnoses that included aftercare following digestive tract surgery and pressure injuries (skin and underlying soft tissue damage occurring from prolonged pressure). A progress note dated August 21, 2024, at 3:34 PM revealed that Resident 260 was admitted with an unstageable pressure ulcer to sacrum, 6.0 cm by 3.5 cm by 0.0 cm with wound base covered with 100% black eschar (dead tissue that forms over healthy skin and then, over time, falls off). The resident was admitted with a stage 3 pressure ulcer (pressure ulcers that have progressed to the third stage have broken completely through the top two layers of the skin and into the fatty tissue below) to the left ischial tuberosity, which is the bony part of the buttocks on the left side, just under the hip. The wound base was 80% covered with a thin beige drainage, leaving 20% of pink tissue exposed. According to The Merck Manual Professional Version, 2024, Pressure injuries can cause significant pain. Pain should be monitored regularly using a pain scale. Primary treatment of pain is treatment of the injury itself, but a nonsteroidal anti-inflammatory drug (NSAID) or acetaminophen is useful for mild-to-moderate pain. Opioids should be avoided, if possible, because sedation promotes immobility. However, opioids or topical non-opioid preparations such as mixtures of local anesthetics may be necessary during dressing changes and debridement. In cognitively impaired patients, changes in vital signs can be used as indicators of pain. A care plan dated August 21, 2024, indicated that Resident 260 has the potential for pain related to her stage IV sacrum pressure ulcer (a stage IV pressure ulcer may extend through the skin into the muscle, tendons, and joints). Interventions in place to assist Resident 260 with her pain included: Administering medication per physician's orders. (continued on next page)

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	395298	A. Building B. Wing	08/30/2024

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Monitor for changes in behavior that may be indicators of pain (e.g., screaming, babbling, cursing, repetitive questions, pacing, kicking, scratching, or refusals for treatments). Monitor for changes in mood that may be indicators of pain (e.g., increased agitation). A physician's order for Resident 260 to receive Ultram oral tablet 50 mg (Tramadol HCl) by mouth every 8 hours as needed for moderate to severe pain 7-10 initiated on August 22, 2024. A progress note dated August 22, 2024, at 4:58 AM revealed that Resident 260 was very agitated, yelling out and unable to be redirected. Care was provided, and the resident was repositioned for comfort without success. There was no documented evidence to determine if the resident's behavior was related to pain. A physical therapy evaluation and treatment plan dated August 22, 2024, revealed the resident verbally reported her pain level. The assessment revealed the resident experiences a pain intensity of 5/10 (moderate pain) during movement, occurring intermittently. The pain is localized in her spine and is described as aching, chronic, and shooting. According to the physical therapy note, this pain significantly impairs the resident's ability to sit and change positions. The note further states the resident experiences pain relief when remaining still or changing body positions. There was no documented evidence that Resident 260 received any pharmacological or non-pharmacological interventions to manage her pain following the physical therapy evaluation on August 22, 2024. A clinical record review revealed that on August 25, 2024, at 2:42 AM, Resident 260 experienced pain of 2 out of 10 (mild pain). There was no documented evidence that Resident 260 received any pharmacological or non-pharmacological interventions to manage her pain at this time. A nursing progress note dated August 26, 2024, at 9:25 PM revealed the resident's family member requested the nurse to call the physician regarding pain medication. The physician ordered Ultram 100 mg via G-tube every 6 hours, for pain level 7-10 (moderate to severe pain) complete a pain assessment every shift for 24 hours. May provide non pharmacological interventions for pain such as repositioning, back rub, music, warm/cool compress or diversional activities. There was no documented evidence that Resident 260 received any pharmacological or non-pharmacological interventions to manage her pain on August 26, 2024 at 9:25 PM. A clinical record review revealed that on August 26, 2024, at 1:11 AM, Resident 260 experienced pain of 5 out of 10 (moderate pain). There was no documented evidence that Resident 260 received any pharmacological or non-pharmacological interventions to manage her pain at this time even though there was an order to administer Ultram. A physician's order for Resident 260 to receive Norco oral tablet 5-325 mg (Hydrocodone-acetaminophen) every 4 hours as needed for moderate to severe pain 4-10 was initiated on August 27, 2024. A physician's order for Resident 260 to receive acetaminophen tablet 325 mg every 6 hours as needed for pain was initiated on August 27, 2024. (continued on next page)

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	395298	A. Building B. Wing	08/30/2024

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F 0697 Level of Harm - Actual harm Residents Affected - Few	An occupational therapy treatment note dated August 27, 2024, recorded that the resident was able to tolerate sitting for approximately 30 minutes but reported pain associated with a sacral wound. The nurse was promptly informed. During an interview on August 29, 2024, at approximately 11:30 AM, Employee 2, Certified Occupational Therapy Aide, confirmed she worked with the resident between 10:00 AM and 11:30 AM on August 27, 2024. She indicated that Resident 260 was experiencing pain that interfered with the resident's ability to participate in her therapy session. During an interview on August 27, 2024, at 11:45 AM, Resident 260's husband indicated his wife has been in pain since the previous night and has not received anything to help her with her pain. He explained she has a pressure injury on her sacrum that is hurting her. Resident 260's husband indicated he is frustrated because his family has been trying to get the facility to do something for his wife's pain since last night (August 26, 2024) at 6:30 PM, but nothing has been done. He explained his wife was acting out last night because of her pain. He indicated the facility reported they were not able to provide his wife pain medication because the physician did not send a prescription to the pharmacy. Resident 260's husband indicated he arrived at the facility this morning at 8:00 AM and still nothing has been done. A progress note dated August 27, 2024, at 12:05 PM revealed that Resident 260 has pain level 3 out of 10 when at rest related to an unstageable pressure wound on her right buttock. There was no assessment regarding Resident 260's pain when moving or shifting positions. During an interview on August 27, 2024, at 12:20 PM, Resident 260 was lying in her bed and described her pain as lousy. The resident did not respond when asked what her pain level was, on a scale of 1 to 10. During an interview on August 27, 2024, at 12:25 PM, Employee 1, Licensed Practical Nurse, indicated she is aware that Resident 260's family is indicating that Resident 260 has been in pain, but explained that she was unable to obtain the resident's pain medication from the facility's medication system. During an interview on August 27, 2024, at 12:30 PM, Employee 3, Corporate Nurse Consultant, explained that Resident 260 was not provided pain medication because the pharmacy indicated they never received a prescription from the physician. An order was implemented, but the pharmacy did not release the medication because they never received the prescription. Employee 3, Corporate Nurse Consultant, was not able to provide documented evidence that Resident 260 received non-pharmacological interventions or other medication interventions for pain from 6:30 PM on August 26, 2024, until August 27, 2024, at 12:35 PM. Employee 3, Corporate Nurse Consultant, was unable to provide documented evidence that Resident 260 had any pharmacological interventions available for use until August 27, 2024, at 12:35 PM. A review of the medication administration record revealed that Resident 260 was administered Norco Oral Tablet 5-325 (hydrocodone-acetaminophen) for severe pain level 8 out of 10 (severe pain) on August 27, 2024, at 12:40 PM. A follow-up evaluation of the resident's pain revealed that her pain was 5 out of 10. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395298	A. Building B. Wing	08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lakewood Rehabilitation & Healthcare Center	147 Old Newport Street Nanticoke, PA 18634

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F 0697 Level of Harm - Actual harm Residents Affected - Few	During an interview on August 30, 2024, at approximately 9:30 AM, the Corporate Administrator was not able to explain why Resident 260's did not receive any interventions for her severe pain from August 26, 2024, at 6:30 PM until August 27, 2024, at 12:40 PM. The Corporate Administrator was not able to explain why the facility failed to ensure pain medications were available to relieve Resident 260's pain. The Corporate Administrator confirmed it is the facility's responsibility to ensure that pain management is provided timely to residents who are experiencing pain. Refer F710 28 Pa. Code 211.2 (d)(9)(10) Medical director. 28 Pa. Code 211.12 (d)(1)(3)(5) Nursing services.

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	395298	A. Building B. Wing	08/30/2024

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F 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Obtain a doctor's order to admit a resident and ensure the resident is under a doctor's care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48276 Based on a review of clinical records, select facility policy, and staff, resident and resident family interviews, it was determined the facility failed to ensure the physician provided services that met the resident's immediate care and needs for two out of 24 residents reviewed (Residents 77 and 260). Findings include: A review of policy titled Medication Orders: Prescriber Medication Orders, last reviewed by the facility on July 21, 2024, revealed that medication is administered only upon the clear, complete, and signed order of a person lawfully authorized to prescribe. A review of policy titled Medication Ordering and Receiving from Pharmacy : Ordering and Receiving Controlled Medications, last reviewed by the facility on July 21, 2024, revealed that medications included in the Drug Enforcement Administration (DEA) classification as controlled substances and medications classified as controlled substances by state law, are subject to special ordering, receipt, and recordkeeping requirements in the facility, in accordance with federal and state laws and regulations. The policy indicates scheduled II controlled medication prescribed for a specific resident is delivered to the facility on ly if a faxed or original written prescription has been received by the pharmacy. A clinical record review revealed Resident 260 was admitted to the facility on [DATE], with diagnoses that included aftercare following digestive tract surgery and pressure injuries (skin and underlying soft tissue damage occurring from prolonged pressure). A clinical record review revealed Resident 260 experienced untreated pain related to prescriptions not being sent by to the facility pharmacy. A progress note dated August 26, 2024, at 9:25 PM revealed that notification was received from Resident 260's family member to call the physician again due to pain medication order changes and telephone verbal order received from physician. During an interview on August 27, 2024, at 11:45 AM, Resident 260's husband indicated that his wife has been in pain since the previous night and has not received anything to help her with her pain. He explained that she has a pressure injury on her sacrum that is hurting her. Resident 260's husband indicated that he is frustrated because his family has been trying to get the facility to do something for his wife's pain since last night (August 26, 2024) at 6:30 PM, but nothing has been done. He explained that his wife was acting out last night because of her pain. He indicated the facility reported they were not able to provide his wife pain medication because the physician did not send a prescription to the pharmacy. Resident 260's husband indicated that he arrived at the facility this morning at 8:00 AM and still nothing has been done to relieve the resident's pain (continued on next page)

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	395298	A. Building B. Wing	08/30/2024

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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 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on August 27, 2024, at 12:25 PM, Employee 1, Licensed Practical Nurse, indicated that she is aware that Resident 260's family is indicating that Resident 260 has been in pain, but explained that she was unable to obtain the resident's pain medication from the facility's medication storage system. During an interview on August 27, 2024, at 12:30 PM, Employee 3, Corporate Nurse Consultant, explained that Resident 260 was not provided pain medication because the pharmacy indicated they never received a prescription from the physician. An order was implemented, but the pharmacy did not release the medication because they never received the prescription. Employee 3, Corporate Nurse Consultant, was not able to provide documented evidence that Resident 260 received non-pharmacological interventions or other medication interventions for pain from 6:30 PM on August 26, 2024, until August 27, 2024, at 12:35 PM. Employee 3, Corporate Nurse Consultant, was unable to provide documented evidence that Resident 260 had any pharmacological interventions available for use until August 27, 2024, at 12:35 PM. During an interview on August 30, 2024, at approximately 9:30 AM, the Corporate Administrator was not able to explain why Resident 260 did not receive any interventions for her severe pain from August 26, 2024, at 6:30 PM until August 27, 2024, at 12:40 PM. The Corporate Administrator was not able to explain why the facility failed to ensure the physician sent a prescription to the pharmacy to release medication to treat Resident 260's pain. The Corporate Administrator confirmed that it is the facility's responsibility to ensure physician services are provided that meet residents' immediate needs. A clinical record review revealed Resident 77 was admitted to the facility on [DATE], with diagnoses that included diabetes mellitus (a chronic disease that occurs either when the pancreas does not produce enough insulin or when the body cannot effectively use the insulin it produces). A review of Resident 77's care plan revealed he uses an indwelling urinary catheter related to neuromuscular dysfunction of the bladder initiated on February 14, 2023. A community hospital emergency department discharge document dated August 27, 2024, at 12:33 AM indicated Resident 77 was evaluated with no evidence of continued hematuria (blood in urine). Resident 77 was to be discharged back to the facility with a urology follow-up appointment scheduled and prescribed Keflex 500 mg oral capsule for dysuria (pain or discomfort when urinating) 1 capsule by mouth two times a day at 6:00 PM and 11:00 PM and penile pain. The document indicated to follow up with the resident's physician in one to two days. A physician's order for Resident 77 to receive Keflex Oral Capsule 500 MG (Cephalexin) with instructions to give 1 capsule by mouth every 8 hours for mild pain related to urinary tract infection initiated on August 28, 2024. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395298	A. Building B. Wing	08/30/2024

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F 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on August 29, 2024, at approximately 1:15 PM, Employee 9, Infection Preventionist (IP), indicated that Resident 77 returned from the community hospital on August 27, 2024, and was receiving Keflex Oral Capsule 500 mg. Employee 9, IP, indicated she did not have a laboratory services report to ensure the antibiotic medication was a necessary medication. Employee 9 indicated the facility physician is able to access the community provider laboratory services report information. Employee 9, IP, indicated she communicated to the facility physician earlier today but did not receive a response regarding the antibiotic medication and laboratory results for Resident 77. Employee 9, IP, was unable to explain the delay in communication. A community provider laboratory services bacteriology report indicated that Resident 77's urine culture was collected on August 27, 2024, and reported on August 28, 2024, at 8:39 AM. The report indicated that Resident 77's urine test showed a low level of less than 10,000 colonies per ml (a urine culture of less than 10,000 units per milliliter of gram-negative rods is considered normal and is not an indicator of an infection) therefore not requiring the use of an antibiotic medication. A clinical record review revealed Resident 77 received five doses of Keflex Oral Capsule 500 mg (Cephalexin) after the community provider laboratory services bacteriology report on August 28, 2024, at 8:39 AM. During an interview on August 30, 2024, at approximately 11:30 AM, the Director of Nursing (DON) was not able to explain the delay in communication with the facility physician and Employee 9, infection Preventionist. The DON confirmed that Resident 77 received five doses of Keflex Oral Capsule 500 mg after the bacteriology report indicated Resident 77 did not have an infection. The DON confirmed it is the facility's responsibility to ensure physician services are provided that meet residents' immediate needs. Refer F697 and F757 28 Pa. Code 211.2 (d)(3)(5) Medical Director 28 Pa. Code 211.12 (d)(3) Nursing Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395298	A. Building B. Wing	08/30/2024

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21738 Based on clinical record review and staff interview, it was determined the facility failed to ensure the physician wrote a progress note with each visit for one of 24 sampled residents (Resident 27). Findings include: According to regulatory guidance at 483.30 (b) the physician must write, sign, and date progress notes at each visit. A review of the clinical record revealed that Resident 27 was admitted to the facility on [DATE], with diagnoses which included dementia (chronic or persistent disorder of the mental processes caused by brain disease or injury and marked by memory disorders, personality changes, and impaired reasoning) and diabetes. Resident 27's clinical record revealed on August 6, 2024, the attending physician was in the facility on this date to see this resident. However, there was no physician progress note in the resident's clinical record to correspond with the noted physician visit on August 6, 2024. Interview with the regional nurse consultant on August 30, 2024, at 10:00 AM failed to provide documented evidence that a physician progress note for the visit on August 6, 2024, was documented in the resident's clinical record. 28 Pa. Code 211.2 (d)(8) Medical director 28 Pa. Code 211.5(f) Medical records.

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	395298	A. Building B. Wing	08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lakewood Rehabilitation & Healthcare Center	147 Old Newport Street Nanticoke, PA 18634

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that the resident and his/her doctor meet face-to-face at all required visits. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48277 Based on clinical record review and staff interview, it was determined the facility failed to ensure that one resident of 24 sampled was seen timely by a physician for the initial comprehensive visit (Resident 91). Findings include: A review of the clinical record for Resident 91 revealed admission to the facility on [DATE] with diagnosis to include dementia (a chronic or persistent disorder of the mental processes caused by brain disease or injury and marked by memory disorders, personality changes, and impaired reasoning), and abnormalities of gait and mobility. A review of nursing notes from July 24, 2024 through August 13, 2024, revealed Resident 91 exhibited agitation and physical aggression toward staff, wandering and exit seeking behaviors, Foley catheter self-removal (Foley catheter is a plastic tube inserted into the bladder and draining into a collection bag), a medication error, and five falls with the last fall on August 13, 2024, resulting in a left hip fracture. On August 14, 2024, resident 91 was admitted to the hospital for treatment of the hip fracture and readmitted to the facility on [DATE]. There was no documented evidence at time of the survey ending August 30, 2024, the physician visited the resident to conduct an initial comprehensive assessment within 30 days of the resident's initial admission to the facility. Interview with Employee 6 (Chief Nursing Officer) on August 30, 2024 at approximately 10:00 AM confirmed that the physician did not complete the initial visit for Resident 91 within 30 days of the resident's initial admission as required. 28 Pa. Code 201.18 (e)(3) Management 28 Pa Code 211.2(d)(3)(9)(10) Medical Director

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	395298	A. Building B. Wing	08/30/2024

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 21738 Based on observation, a review of clinical records, and resident and staff interviews it was determined that the facility failed to provide sufficient nursing staff to consistently provide timely quality of care, services, and supervision necessary to maintain the physical and mental well-being of the residents for two of two nursing units including care, service, and supervision provided to Residents 41, 39, and 77. Finding include: During interview on August 27, 2024, at 11:00 AM Resident 41, a cognitively intact resident, noted that she wishes communication between regular and agency staff was better. Resident 41 stated that approximately three weeks ago on third shift she waited approximately two hours for her call bell to be answered and offered the bed pan. During an interview on August 27, 2024, at 11:15 AM, Resident 77, a cognitively intact resident, indicated he is worried his blood sugar is high because of the way he feels. He explained he was in the community hospital this morning and returned to the facility at 8:30 AM, but he hasn't received his morning insulin medication. Resident 77 indicated he knows he needs coverage for high blood sugar, because he doesn't feel well right now. During an observation and interview on August 27, 2024, at 11:35 AM, Employee 1, Licensed Practical Nurse, indicated she was late administering Resident 77's insulin medication because she was overwhelmed with her workload. Employee 1, LPN, indicated she needed to assist other residents and there was not any other staff available to cover her medication administration duties. She explained she is now behind on medication administration. As a result, Resident 77 received the following Insulin medications outside of physician's orders for administration times: A review of Resident 77 Medication Administration Record for August 2024 revealed: August 27, 2024: Administration time for Novolog Injection Solution 100 unit/ml (Insulin Aspart) was 11:31 AM (1 hour and 31 minutes late). August 27, 2024: Administration time for Novolog Injection Solution 100 unit/ml (Insulin Aspart) sliding scale was 11:31 AM (1 hour and 31 minutes late). August 27, 2024: Administration time for Toujeo Solostar subcutaneous solution pen-injector 300 unit/ml (Insulin Glargine) was 11:31 AM (2 hours and 31 minutes late). Observation on the East Nursing Unit Long Hall unit on August 29, 2024, at 8:40 AM revealed only Employee 11 (agency LPN) on the unit passing medications there were no nurse aides observed at this time. (continued on next page)

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	395298	A. Building B. Wing	08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lakewood Rehabilitation & Healthcare Center	147 Old Newport Street Nanticoke, PA 18634

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During the observation, Resident 39 was yelling from his room for help with breakfast and stating I'm hungry. This surveyor entered Resident 39's room and observed the resident's breakfast tray was on his over-the bed table next to him. The cover was still on the plated food and the tray was not yet set-up for the resident to consume. Resident 39 also stated that he needed to be repositioned before he could eat. Following this surveyor's entry into Resident 39's room, Employee 9 (nurse aide) and Employee 10 (nurse aide) entered the room to reposition the resident. Employee 9 noted that she had just placed the resident's tray down shortly before and had to assist other residents. Employee 10 (nurse aide) and Employee 9 (nurse aide) confirmed that Resident 39 requires the assistance of two staff members for repositioning. Interview with employee 10 (nurse aide) on August 29, 2024, at approximately 9:00 AM confirmed that it was a difficult day due to a call off and noted that having only two aides on the hall prolonged resident wait times. Employee 10 confirmed she was assigned 14 residents and there were multiple residents on the East Long Hall who require the assistance of two staff members for bed mobility and transfers. Employee 10 stated that there were also three residents who were dependent on staff to be fed their meals. Observation on the East Nursing Unit Long Hall on August 30, 2024, at 8:20 AM revealed that again there were two nurse aides and one LPN assigned to the East Nursing Unit Long Hall. Interview with employee 12 (LPN) at this time revealed that staffing at the facility is a concern and staff call-offs make it difficult to timely meet the residents' needs. Interview with the regional staffing coordinator on August 30, 2024, at 8:30 AM revealed two nurse aides and the registered nurse supervisor had called off for the dayshift. The regional staffing coordinator noted that currently the director of nursing was filling in as the dayshift registered nurse supervisor due to a replacement not being found for the dayshift registered nurse supervisor. Interview with the administrator on August 30, 2024, 2024, at approximately 10:00 AM, was unable to provide documented evidence the facility was staffing adequately and deploying staff in a manner to ensure residents' needs are timely met. 28 Pa. Code 211.12(c)(d)(1)(3)(4)(5) Nursing services 28 Pa. Code 201.18(e)(1)(3)(6) Management

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395298	A. Building B. Wing	08/30/2024

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Lakewood Rehabilitation & Healthcare Center	147 Old Newport Street Nanticoke, PA 18634

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Some	Post nurse staffing information every day. 26142 Based on observation and staff interview, it was determined the facility failed to accurately post daily nurse staffing information by failing to reflect staff absences due to call-outs and illness. Findings include: Observation of facility posted nursing time on August 30, 2024, at 10:00 AM revealed the posted day shift nurse aide staff did not reflect a facility call-off and listed one more nurse aide than was present for the dayshift. During an interview on August 30, 2024, at approximately 10:30 AM, the regional nurse consultant confirmed that the posted nursing time was not timely updated to reflect the call-off. 28 Pa. Code: 211.12 (c)(d)(4) Nursing Services

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	395298	A. Building B. Wing	08/30/2024

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48277 Based on observation, and staff interviews it was determined that the facility failed to store drugs and pharmacy supplies in a safe manner in one medication storage room out of two medication storage rooms and failed to remove medications awaiting final disposition in a timely manner and failed to document the accounting and disposition of residents' medications in the clinical record upon discharge of two of two sampled residents (Residents 108 and 107) and failed to ensure accurate narcotic accountability for one of 6 residents sampled (Resident 84). Findings include: Observation of the East Wing medication storage room conducted on [DATE], at approximately 11:50 AM, in the presence of Employee 8 (Registered Nurse Supervisor), revealed a large paper bag on top of a filing cabinet, filled with 12 discontinued resident medication blister cards, 75 plastic medication sleeves, and 8 boxes of resident breathing treatments that were left unsecured. Interview with Employee 8 at the time of the observation, confirmed the medications were all discontinued resident medications that were removed from the medication carts and brought into the medication storage room to be returned to the pharmacy. Employee 8 indicated the pharmacy makes deliveries on a daily basis, and it was his understanding the medications should be picked up by pharmacy personnel. He was uncertain of the timeframe which the pharmacy picks up discontinued medication. Employee 8 confirmed the discontinued medications should have been returned to pharmacy in a timely manner and the medications should have been stored in a secured manner to prevent unauthorized access and the potential for a drug diversion (illegal redirection or misuse of prescription medications). During an interview with Employee 6 (Chief Nursing Officer) on [DATE], at approximately 1:00 PM, she stated that discontinued resident medications are not returned to the pharmacy but instead destroyed at the facility. Employee 6 indicated that nursing staff should have destroyed the medication at the time of discontinuation or discharge. Employee 6 confirmed the medications were not destroyed in a timely manner which could lead to a potential drug diversion. A clinical record review revealed Resident 108 was admitted to the facility on [DATE], and discharged on [DATE]. There was no documented evidence in the resident's clinical record of an accounting of the resident's medications upon discharge. A clinical record review revealed Resident 107 was admitted to the facility on [DATE], and expired at the facility on [DATE]. There was no documented evidence in the resident's clinical record of an accounting of the resident's medications upon discharge. Clinical review revealed that Resident 84 was admitted to the facility on [DATE] with diagnosis to include, anxiety. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395298	A. Building B. Wing	08/30/2024

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A physicians order dated [DATE] revealed Klonopin 0.5 mg (an antianxiety medication) give 0.5 mg by mouth every 8 hours for agitation. This Physicians order was discontinued [DATE]. A physicians order dated [DATE] revealed Klonopin 1 mg every 8 hours by mouth for agitation. A review of the [DATE] MAR (medication administration record) indicated that all the doses of the Klonopin 0. 5 mg every 8 hours (Physician ordered from [DATE] through [DATE])and the Klonopin 1 mg every 8 hours (currently Physician ordered from [DATE]) were given to the resident as ordered. A review of the controlled substance record for Klonopin 0.5 mg tabs revealed that 27 tablets were received by the pharmacy on [DATE]. The administration instructions on the card were covered with a sticker stating directions changed, refer to chart. Hand written on the form was give 2 tablets. Further review of the narcotic sign out form indicated that on [DATE] at 9:42 PM, 2 of the Klonopin 0.5 mg tabs were administered to the resident. The next entry on the form was dated [DATE] at 2:16 PM, 2 Klonopin 0.5 mg tablets administered to the resident. This entry, date and time is noted to be prior to the above entry. There was no explantation given by nursing administration for this. The narcotic administration form indicated that [DATE] at 6 A.M. and at 2 P.M., one 0.5 mg Klonopin tablet were administered to the resident (should have been 2 Klonopin 0.5 tablets, totaling 1 mg with each administration). The facility failed to ensure accurate narcotic administration and accounting for this resident. During an interview on [DATE], at approximately 10:30 AM, the Nursing Home Administrator confirmed that the quantity and disposition of medications upon Resident 108 and Resident 107's discharge from the facility was not documented on the residents' records. Further confirming accurate narcotic accounting for Resident 84. 28 Pa Code 211.12 (c)(d)(1)(3)(5) Nursing services. 28 Pa Code 211.9 (a)(1)(d)(j.1)(1)(2)(3)(4)(5)(k) Pharmacy services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395298	A. Building B. Wing	08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lakewood Rehabilitation & Healthcare Center	147 Old Newport Street Nanticoke, PA 18634

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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** 48276 Based on a review of clinical records and staff interview, it was determined the facility failed to ensure the resident's drug regimen was free of unnecessary antibiotic medication for one out of 24 residents sampled (Residents 77). Findings included: A clinical record review revealed Resident 77 was admitted to the facility on [DATE], with diagnoses that included diabetes mellitus (a chronic disease that occurs either when the pancreas does not produce enough insulin or when the body cannot effectively use the insulin it produces). A review of Resident 77's care plan revealed he uses an indwelling urinary catheter related to neuromuscular dysfunction of the bladder initiated on February 14, 2023. A community hospital emergency department document dated August 27, 2024, at 12:33 AM indicated Resident 77 was evaluated with no evidence of continued hematuria (blood in urine). Resident 77 was to be discharged back to the facility with a urology follow-up and prescribed Keflex 500 mg oral capsule for dysuria (pain or discomfort when urinating) and penile pain. The document indicated to follow up with the physician in one to two days. A progress note dated August 27, 2024, at 8:30 AM revealed Resident 77 returned from the community emergency department with a diagnosis of a urinary tract infection and a new order of Keflex (Cephalexin- an antibiotic medication). A progress note dated August 27, 2024, at 8:30 AM revealed Resident 77 ' s orders were being reviewed by the Registered Nurse Supervisor. A physician ' s order for Resident 77 to receive Keflex Oral Capsule 500 MG (Cephalexin) with instructions to give 1 capsule by mouth every 8 hours for mild pain related to urinary tract infection initiated on August 28, 2024. A progress note dated August 28, 2024, at 5:53 PM revealed the resident's Foley catheter was examined and intact. The note indicated the resident ' s urine is light yellow, and he denied pain or discomfort. There was no documented evidence the resident had experienced any further symptoms of a urinary tract infection, such as fever, chills, mental changes/confusion, fatigue, nausea/vomiting, pressure in the lower part of the pelvis, or an increase in urination. A review of Resident 77 ' s Medication Administration Record for August 2024 revealed that Resident 77 received Keflex Oral Capsule 500 mg (Cephalexin) on August 27, 2024, at 7:00 PM and on August 27, 2024, at 11:00 PM A review of Resident 77 ' s Medication Administration Record for August 2024 revealed that Resident 77 received six doses of Keflex Oral Capsule 500 mg (Cephalexin) for mild pain related to urinary tract infection on August 28, 2024, at 6:00 AM ans 10:00PM, on August 29, 2024, at 6:00 AM, 2:00 PM and 10:00 PM and on August 30, 2024, at 6:00 AM. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395298	A. Building B. Wing	08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lakewood Rehabilitation & Healthcare Center	147 Old Newport Street Nanticoke, PA 18634

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on August 29, 2024, at approximately 1:15 PM, Employee 9, Infection Preventionist (IP), indicated that Resident 77 returned from the community hospital on August 27, 2024, and was receiving Keflex Oral Capsule 500 mg. Employee 9, IP, indicated that she did not have a culture and sensitivity report (a urine culture is 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) from the community provider to ensure that the antibiotic medication was a necessary medication. Employee 9 indicated that the facility physician is able to access the community provider laboratory services report information. Employee 9, IP, indicated that she communicated to the facility physician earlier today but did not receive a response. During the survey, the Director of Nursing contacted the lab and confirmed that the lab never completed Resident 1's culture and sensitivity in response to the abnormal urinalysis dated August 16, 2023, and the CRNP should have waited for the C & S report prior to ordering the antibiotic to ensure its efficacy in the treating the identified infectious organism. A community provider laboratory services bacteriology report indicated that Resident 77 ' s urine culture was collected on August 27, 2024, and reported on August 28, 2024, at 8:39 AM. The report indicated that Resident 77 ' s urine test showed a low level of less than 10,000 colonies per ml (a urine culture of less than 10,000 units per milliliter of gram-negative rods is considered normal and not indicative of an infection). Resident 77 received five doses of Keflex Oral Capsule 500 mg (Cephalexin) after the community provider laboratory services bacteriology report on August 28, 2024, at 8:39 AM. During an interview on August 30, 2024, at approximately 11:30 AM, the Director of Nursing confirmed that Resident 77 ' s laboratory services bacteriology report indicated that the resident did not have a urinary tract infection and the administration of Keflex Oral Capsule 500 mg (Cephalexin) was not clinically justified. The DON was not able to explain the delay in communication with the facility physician and Employee 9, infection Preventionist. Refer 710 28 Pa. Code 211.2 (d)(3) Medical Director 28 Pa. Code 211.9 (k) Pharmacy Services 28 Pa. Code 211.12 (d)(3) Nursing Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395298	A. Building B. Wing	08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lakewood Rehabilitation & Healthcare Center	147 Old Newport Street Nanticoke, PA 18634

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26142 Based on clinical record review, observation and staff interview, it was determined the facility failed to ensure a medication error rate of less than 5% for one of 4 residents (Residents 6) observed. Findings include: A review of the clinical record revealed that Resident 6 was admitted to the facility on [DATE], and had diagnoses that included psychosis, diabetes. A quarterly MDS assessment dated [DATE], indicated the resident was cognitively intact with a BIMS score of 15 (Brief Interview for Mental Status a tool used 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 the resident required limited staff assistance for activities of daily living. A review of current Physicians orders, initiated November 14, 2019 revealed Lactase Tablet(an enzyme ro complete digestion of whole milk), 3000 units by mouth before meals for lactose intolerance to be give at 8:00 AM prior to breakfast, as per residents request. An order dated for May 11, 2023, indicated give 2 tablespoons (30 cc's) of Fiber Powder by mouth one time a day for constipation and mix in 8 ounces or more of a liquid (water). Observation of the medication administration pass on August 29, 2024, at 9:00 AM after the resident consumed her breakfast. revealed Employee 7 placed 2 teaspoons (approximately 10 cc's) of the fiber powder in a plastic cup with approximately 100 cc's of water and administered it to the resident. Employee 7 did not administer the correct amount of fiber powder as ordered by the physician. At the same time Employee 7, agency LPN also administered the lactase tablet to the resident which was after the resident consumed her breakfast and not prior to her breakfast as ordered. The facility's medication error rate was 6.67% based on 30 medication opportunities with two medication errors. Interview with the Director of Nursing on August 29, 2024, at 2 p.m. confirmed te medications were not administered as ordered resulting in a medication error of greater than 5%. 28 Pa. Code 211.12(d)(1)(5) Nursing services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395298	A. Building B. Wing	08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lakewood Rehabilitation & Healthcare Center	147 Old Newport Street Nanticoke, PA 18634

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48277 Based on review of clinical records and staff interview it was determined the facility failed to assure that two residents out of 24 sampled were free of a significant medication error (Resident 5 and 77). Findings include: A review of the clinical record revealed that Resident 5 was admitted to the facility on [DATE], with diagnoses to include congestive heart failure (weakness of the heart that leads to build-up of fluid in the lungs and surrounding body tissues), and atrial fibrillation (an irregular, often rapid heart rate that commonly causes poor blood flow). Resident 5 had a physician order dated August 12, 2024, for Coumadin or Warfarin Sodium tablet 3 MG (anticoagulant or blood thinner to prevent blood clots) to give one tablet by mouth in the evening every Mon, Wed, Fri, Sun for treating/preventing blood clots related to unspecified atrial fibrillation (abnormal heart rhythm). A review of the Medication Administration Record (MAR) for August 2024, revealed Resident 5's Warfarin was scheduled for 9:00 PM. Nursing staff failed to administer the medication to the resident on August 12, 2024, as the medication was not signed out but instead, the code 9 was entered in the MAR for August 12, 2024. Code 9 on the MAR indicated other/see nurse notes. Review of nursing documentation on August 12, 2024, at 10:05 PM revealed the nurse documented pending pharmacy disposition. Review of the facility investigation report dated August 13, 2024, at 9:00 PM indicated that Resident 5's new order for Coumadin (Warfarin) 3 MG was not received timely and the resident missed one dose. The physician was made aware of this omission and physician indicated to continue with the Coumadin as previously ordered to no negative outcome. Interview with the Nursing Home Administrator on August 30, 2024, at 8:38 AM confirmed that Resident 5 missed a dose of her prescribed Warfarin 3 MG on August 12, 2024, and revealed the pharmacy had not timely delivered the Warfarin 3 MG as ordered, resulting in a significant medication error. A clinical record review revealed Resident 77 was admitted to the facility on [DATE], with diagnoses that included diabetes mellitus (a chronic disease that occurs either when the pancreas does not produce enough insulin or when the body cannot effectively use the insulin it produces). A physician's order initiated on August 7, 2024, for Resident 77 to receive Novolog Injection Solution 100 units/mL (Insulin Aspart) with directions to inject 50 units subcutaneously before meals for diabetes mellitus. A physician's order initiated on July 30, 2024 for Resident 77 to receive Novolog Injection Solution 100 unit/ml (Insulin Aspart) with directions to inject per sliding scale if blood sugar levels were as follows: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395298	A. Building B. Wing	08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lakewood Rehabilitation & Healthcare Center	147 Old Newport Street Nanticoke, PA 18634

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	151-200 mg/dl = 4 units, 201-250 mg/dl= 6 units, 251-300 mg/dl = 8 units, 301-350 mg/dl= 10 units, 351-400 mg/dl= 12 units, [PHONE NUMBER]= 14 units and call physician for further orders, subcutaneously before meals at bedtime for diabetes mellitus. A physician's order initiated on August 8, 2024 for Resident 77 to receive Toujeo Solostar subcutaneous solution pen-injector 300 units/ml (Insulin Glargine) with directions to inject 70 units subcutaneously two times a day for diabetes mellitus. During an interview on August 27, 2024, at 11:15 AM, Resident 77 expressed concern that his blood sugar might be elevated based on how he was feeling. He explained that earlier that morning, he had been at the community hospital and returned to the facility at 8:30 AM, but had not yet received his morning insulin. Resident 77 indicated that he felt he needed insulin coverage for high blood sugar, as he was not feeling well. During an observation on August 27, 2024, at 11:30 AM, Employee 1, a Licensed Practical Nurse (LPN), administered Resident 77 the following medications: -Toujeo Solostar subcutaneous solution pen-injector 300 units/mL (Insulin Glargine) 9:00 AM dose. -Novolog Injection Solution 100 units/mL (Insulin Aspart) 10:00 AM dose. -Novolog Injection Solution 100 units/mL Sliding Scale (Insulin Aspart) 10:00 AM dose. A review of Resident 77's Medication Administration Record (MAR) showed that Resident 77's blood sugar was recorded as 519 mg/dL on August 27, 2024, at 10:00 AM. Resident 77's MAR revealed he received the following insulin medications late on August 27, 2024: -9:00 AM dose of Toujeo Solostar subcutaneous solution pen-injector 300 units/mL (Insulin Glargine) was administered at 11:31 AM (2 hours and 31 minutes late). -10:00 AM dose of Novolog Injection Solution 100 units/mL (Insulin Aspart) was administered at 11:31 AM (1 hour and 31 minutes late). -10:00 AM sliding scale dose of Novolog Injection Solution 100 units/mL (Insulin Aspart), 14 units of coverage, was administered at 11:31 AM (1 hour and 31 minutes late). During an interview on August 27, 2024, at 11:35 AM, Employee 1, a Licensed Practical Nurse (LPN), acknowledged that she was late in administering Resident 77 ' s insulin. She explained that she had been overwhelmed with her workload and was behind on medication administration after assisting other residents thus administering multiple Insulins at the same time not according to physician orders During a medication administration observation of the aforementioned Resident 77 on August 28, 2024 at 8:44 AM, the day after the above observation and clinical record review, Employee 7 (agency LPN) completed a blood glucose fingerstick (blood sugar monitoring . The recommended ranges are for most people with diabetes, target range may be before meals: 80 to 130 mg/dL) which resulted in a blood glucose level of 345 mg/dl. Employee 7(agency LPN) administered 10 units of Novolog Injection Solution 100 unit/ml (Insulin Aspart) at that time. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395298	A. Building B. Wing	08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lakewood Rehabilitation & Healthcare Center	147 Old Newport Street Nanticoke, PA 18634

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Both the blood glucose check and the insulin injection were preformed while the resident was eating breakfast not prior to eating the meal as per the Physician's order. During an interview on August 28, 2024, at approximately 1:30 PM, the Director of Nursing confirmed that licensed and professional nursing staff failed to ensure the timely administration of medication to manage Resident 77's diabetes mellitus. Refer F725 28 Pa. Code 211.10(c) Resident care policies. 28 Pa. Code 211.12 (c)(d)(1)(3)(5) Nursing Services. 28 Pa. Code 211.9 (a)(1)(k)(l)(2) Pharmacy Services.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395298	A. Building B. Wing	08/30/2024

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 48277 Based on observation, review of select facility policy and clinical records, and staff interviews, it was determined the facility failed to adhere to acceptable storage and use by dates for multi-dose medications in one of two medication storage rooms observed (West medication storage room). Findings include: Review of the facility policy titled Medication labeling and Storage last reviewed by the facility July 1, 2024, indicated that multi-use vials that have been opened or accessed (e.g. needle punctured) are dated and discarded within 28 days unless the manufacturer specifies a shorter or longer date for the open vial. Observation of the medication room on the [NAME] Wing on August 29, 2024, at 11:05 AM, in the presence of Employee 7 (Licensed Practical Nurse) of medication stored in the medication refrigerator, revealed two (2) multi-dose vials of Aplisol (solution used for screening for tuberculosis) that had been opened and available for use, but not dated when initially opened. A review of the manufacturer dosage and administration for Aplisol revealed that vials in use for more than 30 days should be discarded in order to prevent the potential contamination of the medication contained in the vial from frequent needle punctures. Further observation of medication refrigerator revealed one (1) Insulin Lispro Injection KwikPen (medication used for diabetes), belonging to Resident 6, was observed to be opened and available for use and dated July 27, 2024, when initially opened with a discard date of August 25, 2024, 4 days beyond the discard date. Employee 7 confirmed the medication belonged to Resident 6, and the insulin was beyond the manufacturer recommended use by date (28 days) and had not been discarded within 28 days of opening. Employee 3 also confirmed that the Aplisol vials were opened and not dated. Interview with the Nursing Home Administrator (NHA) on August 30, 2024, at approximately 8:00 AM, confirmed that the facility failed to adhere to acceptable storage and use by dates for multi-dose medications. 28 Pa. Code 211.9(a)(1)(k) Pharmacy services 28 Pa. Code 211.12(c)(d)(1)(5) Nursing services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395298	A. Building B. Wing	08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lakewood Rehabilitation & Healthcare Center	147 Old Newport Street Nanticoke, PA 18634

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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** 48277 Based on review of clinical records and staff interview, it was determined the facility failed to offer routine annual dental services for one resident with a Medicaid payor source out of 24 residents sampled (Resident 80). Findings include: Review of Resident 23's clinical record revealed admission to the facility on [DATE], and the resident's current payor source was Medicaid. There was no documented evidence at the time of the survey ending August 30, 2024, the resident had been offered dental services in the past year. Interview with the Nursing Home Administrator on August 29, 2024, at 12:35 PM confirmed the facility had not offered Resident 80 routine dental services in the past year. 28 Pa. Code 211.12 (c)(d)(3)(5) Nursing services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395298	A. Building B. Wing	08/30/2024

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Lakewood Rehabilitation & Healthcare Center	147 Old Newport Street Nanticoke, PA 18634

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26142 Based on select facility policy, facility provided documentation, clinical records and staff interview, it was determined the facility's Quality Assurance Performance Improvement (QAPI) committee failed demonstrate effective and thorough adverse event monitoring and response and use of the monitoring data to prevent similar adverse events in the facility in response to residents with repeated falls for 2 of 24 sampled residents (Resident 91 and 33) and implement any applicable performance improvement activities. Findings include: A review of a facility policy for Quality Assurance Performance Improvement reviewed July 2024 revealed, This facility shall develop, implement and maintain an ongoing, facility wide, data driven QAPI program that is focused on indicators of the outcomes of care and quality of life for our residents. The objectives of the QAPI program are to: 1. provide a means to measure current and potential indicators for outcomes of care and quality of life. 2. provide a means to establish and implemnt performance improvement projects to correct identified negative or problematic indicators. 3. reinforce and build upon effective systems and processes related to the delivery of quality care and services. 4. establish systems through which to monitor and evaluate corrective actions. The QAPI plan describes the process for identifying and correcting quality deficiencies. Key components of this process include: 1. tracking and measuring performance 2. establishing goals and thresholds for performance measurement 3. identifying and prioritizing quality deficiencies 4. systematically analyzing underlying causes of systemic quality deficiencies 5. developing and implementing corrective action or performance improvement activities and 6. monitoring or evaluating the effectiveness of corrective action/performance improvement activities and revising as needed. (continued on next page)

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	395298	A. Building B. Wing	08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lakewood Rehabilitation & Healthcare Center	147 Old Newport Street Nanticoke, PA 18634

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The committee meets monthly to review reports, evaluate data and monitor QAPI-related activities and make adjustments to the plan. A review of a 2024 facility incident log revealed monthly resident fall totals as: January- 7 falls February - 11 falls March- 17 falls April- 11 falls May- 15 falls June- 21 falls July- 26 falls August-19 falls Total 127 falls in 8 months. There was no evidence at the time of the survey the increased number falls was identified as a systemic issue and analyzed underlying causes to develop and implement corrective action to prevent future falls. A review of the clinical record for Resident 91 revealed admission to the facility on [DATE], with a diagnosis to include dementia (a chronic or persistent disorder of the mental processes caused by brain disease or injury and marked by memory disorders, personality changes, and impaired reasoning), and abnormalities of gait and mobility (difficulty walking). A review of an admission MDS (Minimum Data Set - a federally mandated standardized assessment conducted at specific intervals to plan resident care) dated July 29, 2024, revealed Resident 91 was severely cognitively impaired with a BIMS score of 0 (BIMS- Brief Interview for Mental Status is a tool to screen and identify the cognitive condition of long-term care residents. A score of 0-7 represents severe cognitive impairment), and she required substantial/maximal assistance of staff for activities of daily living. A review of the care plan dated July 25, 2024, revealed Resident 91 was at risk for falls related to impaired cognition with decreased safety awareness. Interventions included: alarm to bed and wheelchair to alert staff of unsafe transfers, fall mats when in bed, implement preventative fall interventions/devices, maintain call light within reach, educate resident to use call light, maintain needed items within reach, and monitor for changes in mobility. (continued on next page)

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	395298	A. Building B. Wing	08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lakewood Rehabilitation & Healthcare Center	147 Old Newport Street Nanticoke, PA 18634

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of nursing documentation dated July 24, 2024, at 5:54 PM revealed resident 91 was not cooperative with staff on the day of admission, not allowing staff to complete a body audit and clinging to the transport person, refusing to let him go. She was noted to be walking up the hallway without assistance, grabbing onto the side rails. Safety alarms were added to her wheelchair. Nursing documentation dated July 26, 2024, at 7:29 AM indicated the resident pulled out her Foley catheter (a thin flexible tube inserted into the bladder that then drains the urine into a collection bag) and she was trying to exit the building via doors and windows. Resident placed on 1:1 (one-to-one supervision - one staff member is assigned to provide observation and assistance to one resident who is not to be left unattended at any time). A nurses note dated July 26, 2024, at 6:05 PM stated Resident 91 continued to exhibit exit seeking behaviors with agitation and attempts at physical aggression. The physician was contacted, and the resident remained on 1:1 supervision while she is awake. Nursing documentation dated July 31, 2024, at 5:53 AM revealed Resident 91's bed alarm was sounding, and Resident 91 was observed sitting on the floor in her room across from the bathroom door. She was noted to be incontinent of urine at that time. Continue on 1:1 while awake. Brought to the nurses station for close supervision with multiple attempts to stand and difficulty at times to redirect. Resident assisted to bed at 5:30 AM after bathroom use. A nurses note dated August 2, 2024, at 5:39 AM revealed that Resident 91 was on the floor of her bathroom, lying on her right side. Her bed alarm was sounding at the time of the fall. The resident stated, I got up to go to the bathroom. The resident was noted to have a 6 cm x 5 cm bruise to the right upper arm and a 2 cm x 3 cm bruise to the right inner wrist. The nurse assessed the resident, and the physician was notified. The resident was placed near the nurses station. A nurses note dated August 4, 2024, at 5:00 AM stated that Resident 91 was awake most of the night and at the nurses station for close supervision. Continues to attempt to stand and self-transfer. Unable to redirect. A nurses note dated August 7, 2024, at 3:00 AM stated that Resident 91 was found on the floor on the right side of her bed. Fall mats next to the bed were put into place as the intervention to prevent future injuries from falls. A nurses note dated August 7, 2024, at 4:45 PM stated the resident stood up from her wheelchair and fell to the ground. She did not sustain any injuries at that time. A physician's order dated August 7, 2024, revealed the 1:1 supervision order had been discontinued. A nurse note dated August 8, 2024, at 8:25 AM revealed that Resident 91 was continually roaming the building (in her wheelchair), exit seeking, self-transferring, and unable to be redirected. She was found lying on the bench outside of the facility chapel (located in the front of the facility away from resident areas). She was returned to the nurses station. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395298	A. Building B. Wing	08/30/2024

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A nurse note dated August 13, 2024, at 11:00 AM revealed that Resident 91 was observed lying on her back on the floor in room [ROOM NUMBER] (Resident 91 resides in room [ROOM NUMBER]-A). A full body assessment was completed. The resident was complaining of right hip pain. The physician was contacted, and an X-ray of the pelvis was ordered. A review of the X-ray report dated on August 13, 2024, revealed an acute right intertrochanteric hip fracture (fracture of the right hip). The resident was admitted to the hospital on August 14, 2024, and had surgical repair of her right hip on August 15, 2024. At the time of the survey ending August 30, 2024, the facility was unable to provide documented evidence that the physician ordered 1:1 supervision to be provided to Resident 91 during the timeframe it was ordered as an intervention. The facility failed to provide effective safety interventions and sufficient and timely staff supervision, at the level and frequency required, to prevent multiple falls for a resident at risk for falls, with known unsafe behaviors and a history of falls, resulting in a fall with major injury. An interview with the Nursing Home Administrator on August 30, 2024, at 8:00 AM confirmed that the facility failed to provide effective safety interventions and sufficient and timely staff supervision to Resident 91 to prevent repeated falls and injuries. A clinical record review revealed Resident 33 was admitted to the facility on [DATE], with diagnoses that include 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). A review of an admission MDS assessment dated [DATE], revealed that Resident 33 is severely cognitively impaired with a BIMS score of 03 (a score of 01-07 indicates severe impairment). A review of Resident 33's care plan, initiated on June 25, 2024, revealed that she was at risk for falls due to a history of falls and impaired cognition with decreased safety awareness. Interventions to reduce this risk included a bed alarm, bed in the lowest position, wheelchair alarm, and non-skid footwear. A review of facility incident reports revealed from June 25, 2024, to August 26, 2024, Resident 33 sustained 9 unwitnessed falls June 25, 2024 at 6:30 PM, July 2, 2024, at 12:25 PM, July 8, 2024, at 8:26 AM, July 8, 2024, at 10:03 PM, July 15, 2024, at 11:14 AM, July 17, 2024, at 1:30 PM, August 5, 2024, at 2:23 PM, August 14, 2024, at 3:46 PM, and August 26, 2024, at 3:31 PM. Each fall found the resident on the floor in various areas of the facility. The facility did not provide any increased supervison for this specific resident to prevent additional falls. Interview with the NHA (Nursing Home Administrator) on July 29, 2024 at 2 PM confirmed that the facility failed to provide evidence of an effective QAPI program in regards to falls in the facility and took no internal action to attempt to prevent resident falls (continued on next page)

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	395298	A. Building B. Wing	08/30/2024

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	cross refer F689 28 Pa. Code 201.18 (e)(3)(4) Management.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. 26142 Based on observation, review of the facility's infection control tracking logs, facility policy, and staff interviews it was determined the facility failed to maintain a comprehensive program to monitor the development and spread of infections within the facility and plan preventative measures accordingly and failed to ensure the consistent implementation of infection control procedures designed to prevent the potential for the spread of infection during ice storage for one of two resident pantries (East Nursing), medication administration and multi resident use blood glucose monitors for one of 3 residents sampled (Resident 77). Findings include: A review of the facility's infection control data conducted during the survey ending August 30, 2024, revealed the facility's infection control tracking did not reflect evidence of a functional tracking system to monitor and investigate causes of infection and manner of spread. There was no documented evidence of a functional system, which enabled the facility to analyze clusters, changes in prevalent organisms, or increases in the rate of infection in a timely manner. Further review of infection control data revealed the following infections were tracked: January 2024: 3- urinary tract infections (UTI) February 2024: 3-UTI March 2024: 4-UTI April 2024: 3-UTI May 2024: 2-UTI June 2024: incomplete documented infections July 2024: incomplete documented infections Associated tracking documents do not coincide with the tracking documents. It was noted on the tracking documents dated January, February, March, April and May 2024, the urinary tract infections occurred on the same hallways. There was no indication that the limited data that was compiled was then evaluated to determine what could be done to prevent the spread or recurrence of infection. The facility provided staff education dated January and February regarding infection control practices including interventions regarding bladder incontinence. However, there was no evidence that the above noted UTI infections were investigated for a possible cause and associated infection related interventions to prevent urinary tract infections in the facility. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observation of a medication pass August 29, 2024 at 8:44 AM Employee 7 (agency LPN) was preparing medications in the [NAME] hallway for Resident 77's. With gloved hands she poured the following over the counter medications from multi resident use bottles: -Aspirin 81 mg -Calcium 500 mg/Vitamin D2oo units/Vitamin K90mg/tablet -Lactobacilli oral tab 1 cap -Magnesium Oxide oral tab 400mg -Senna 8.8 mg tab -Vitamin C 500 mg An interview with the facility Infection Preventionist (IP) stated that she has been the IP since August 1, 2024. She stated that because of facility staffing issues, she is required to work on the resident floors, being pulled away from her IP duties. She stated that she could not comment about infection control practices prior to taking the IP position August 1, 2024. Employee 7 (agency LPN) dropped the Magnesium Oxide tablet on the mediation cart, picked the pill up with the same gloved hands and put the pill back into the medication cup. Touching the surface of the medication cart and not changing her gloves. Employee 7(agency LPN) with the same gloved hands then took the medication cup, a drink cup with water and a blood glucose monitor, lancet and a test strip into the resident room and placed all on the resident's bedside table, never cleaning the area. With the same gloved hands, the nurse completed the blood glucose monitoring which consisted of obtaining a small blood sample from the resident's finger and then administered the medications to the resident. The nurse then returned to the medication cart, placed the blood glucose monitor back into the medication cart. She did not clean the machine after use. Employee 7(agency LPN) with the same gloved hands drew up the residents insulin and returned to his bedside and administered the insulin. Employee 7 never changed her gloves between multiple tasks after making contact with items that may have been soiled which could potentially spread infection. The nurse again returned to the medication cart. She changed her gloves and started preparing the next residents medications. She never washed her hands or utilized hand sanitizer between residents. During an interview at the time of the observation, Employee 7 (agency LPN) stated she was told that she had to wear gloves to prepare and administer medications to residents. She could not state why she did not wash or sanitize her hands between resident administration of medications. She stated that she did not know she had to clean the blood glucose monitoring machine between resident use to prevent the potential spread of infection. (continued on next page)

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	395298	A. Building B. Wing	08/30/2024

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observation of the East Nursing Unit Pantry on August 30, 2024, at approximately 8:20 AM revealed a portable ice chest on a cart. There was an ice scoop resting on the ice in the cooler with the handle in direct contact with the ice. Interview with the regional nurse consultant on August 30, 2024, at approximately 10:00 AM confirmed that the ice scoop should be stored separately from the ice chest and the handle should not be in direct contact with the ice. The facility failed to maintian ice in a clean and sanitary manner to prevent contamination. 28 Pa. Code 211.10 (a)(d) Resident care policies 28 Pa. Code 211.12 (c)(d)(1)(5) Nursing Services

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21738 Based on review of select facility policy and clinical records, and staff interview, it was determined the facility failed to offer and/or provide the pneumococcal immunization, unless the immunization was medically contraindicated or the resident has already been immunized, to 3 of five residents reviewed (Residents 31, 27 and 91). Findings include: A review of facility policy titled Pneumococcal Vaccine last reviewed July 1, 2024, revealed prior to or upon admission, residents will be assessed for eligibility to receive the pneumococcal vaccine. When indicated, the vaccine will be offered and be administered within 30 days of admission. Assessments of pneumococcal vaccination status are conducted within five working days of the resident's admission if not conducted prior to admission. A review of the clinical record revealed that Resident 31 was admitted to the facility on [DATE], with diagnoses to include cerebral infarction (stroke) and COPD (chronic obstructive pulmonary disease- a group of lung diseases that block airflow and make it difficult to breathe). Review of Resident 31's Pneumococcal and Vaccination Informed Consent signed by Resident 31's resident representative on July 12, 2024, indicated permission for the facility to administer the pneumococcal vaccine. Further review of the clinical record revealed no documented evidence the facility administered the pneumococcal vaccine as requested per the signed consent. A review of the clinical record revealed that Resident 27 was admitted to the facility on [DATE], with diagnoses to include dementia (chronic or persistent disorder of the mental processes caused by brain disease or injury and marked by memory disorders, personality changes, and impaired reasoning) and diabetes. Further review of the resident's clinical record revealed no documented evidence that Resident 27 received the pneumococcal vaccine prior to admission to the facility. The facility was unable to provide documented evidence the pneumococcal vaccine was offered/provided to Resident 27 upon admission as per facility policy or that Resident 27 had previously received the vaccine or that the vaccine was clinically contraindicated. A review of the clinical record for Resident 91 revealed admission to the facility on [DATE], with diagnosis to include dementia (a chronic or persistent disorder of the mental processes caused by brain disease or injury and marked by memory disorders, personality changes, and impaired reasoning), and abnormalities of gait and mobility (difficulty walking). Further review of the resident's clinical record revealed no documented evidence that Resident 91 received the pneumococcal vaccine prior to admission to the facility. (continued on next page)

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	395298	A. Building B. Wing	08/30/2024

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility was unable to provide documented evidence that the pneumococcal vaccine was offered/provided to Resident 91 upon admission as per facility policy or that Resident 91 had previously received the vaccine or that the vaccine was clinically contraindicated Interview with the regional nurse consultant on August 30, 2024, at approximately 9:30 AM confirmed the facility failed to offer and/or provide pneumococcal immunizations to Residents 31, 27, and 91. 28 Pa. Code 201.14(a) Responsibility of licensee. 28 Pa. Code 201.18(b)(1) Management. 28 Pa Code 211.5 (f)(i) Medical records 28 Pa. Code 211.10(a)(d) Resident care policies 28 Pa code 211.12 (c)(d)(1)(5) Nursing Services

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48276 Based on observations, a review of facility provided documents, and resident and staff interview, it was determined the facility failed to maintain an effective pest control program, including observations made on two of the two nursing units (East and West) and experiences reported by two residents out of 24 sampled. (Residents 77 and 90). Findings include: A review of a pest management detailed report dated August 16, 2024, revealed the following summary of recommendations to effectively manage pest and rodent activity at the facility: Recommendations made on May 10, 2024, included all {damaged} exterior grates under windows along the exterior that need to be replaced, which can allow rodents access to the interior. Recommendations made on June 22, 2024, included repairing door gaps that allow pest entrance. Recommendations made on July 10, 2024, included the facility exterior grates needed repairs. Holes leading into air-conditioning units allow rodent travel, fill in gaps between pipes and walls to prevent pest entry into buildings, and repair window gaps or damage that allow pest access. Recommendations made on July 19, 2024, ensuring pedestrian doors remain close to prevent rodent entry. An observation on August 27, 2024, at 11:01 AM in resident room [ROOM NUMBER] revealed brown/black feces like pellets near the window side wall. An observation on August 27, 2024, at 11:05 AM in resident room [ROOM NUMBER] revealed brown/black feces like pellets adjacent to gray tote near the window side wall. An observation on August 27, 2024, at 11:10 AM in resident room [ROOM NUMBER] revealed brown/black feces like pellets under the window side bed near the headboard. During an interview on August 27, 2024, at 11:15 AM, Resident 77 indicated that he saw two mice running through his room earlier this week. During an interview on August 28, 2024, at 10:00 AM, Resident 90 indicated he saw a mouse this week and last week in his room. During a facility tour and interview on August 28, 2024, at approximately 11:30 AM, Employee 4, Maintenance Assistant, confirmed the following observations: The facility's main entry door was ajar, leaving a small gap and rodent access point. Resident room [ROOM NUMBER] exterior vent screen was observed to be loose, allowing a pest entry point into the facility. (continued on next page)

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Resident room [ROOM NUMBER] was observed with a hole in the window screen and an open window allowing for pest or rodent access into the building. Resident room [ROOM NUMBER] was observed with a hole in the window screen allowing for pest or rodent access into the building. Resident room [ROOM NUMBER] exterior vent screen was observed to be pulled away from the vent, allowing for pest or rodent access into the building. A two-inch gap was observed between the wall and air conditioning unit electrical conduit wire entrance point into the building, allowing for pest or rodent access into the building. Resident rooms #101 through #115 were observed to have six exterior grates/vents not covered with protective screen, allowing for rodent and pest entry into the building. Garage exterior pedestrian entrance was observed without a door sweep, allowing for rodent and pest entry into the building. Garage vehicle entrance was observed with a 1 inch gap at the corner of the door when closed, allowing for rodent and pest entry. During an interview on August 28, 2024, at approximately 1:30 PM, the Nursing Home Administrator (NHA) and Director of Nursing (DON) failed to provide evidence the facility addressed recommendations made by the external pest management company to prevent rodent and pest access into the building. The NHA confirmed that its current pest control program failed to effectively manage the rodent activity in the facility. 28 Pa. Code 201.18 (e)(2.1) Management

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F 0943 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Give their staff education on dementia care, and what abuse, neglect, and exploitation are; and how to report abuse, neglect, and exploitation. 26142 Based on staff interviews and a review of employee personnel records it was determined the facility failed to provide abuse prevention training to two employees out of two reviewed. (Employee 7 and 15). Findings include: During an interview with Employee 7 (agency LPN) on August 29, 2024 at 9:45 a.m she stated she had worked a couple of shifts at the facility since July 2024. Employee 7 stated she was never trained on the facility's abuse prohibition policy prior to assuming her duties today. There was no documentation that Employee 7(agency LPN) was trained on the facility's abuse prohibition policies and procedures as part of staff orientation and training on the prohibition of all forms of abuse, neglect, and exploitation prohibition. During an interview with Employee 15 (agency RN supervisor) on August 30, 2024 at 11 a.m she stated this was her first day working at the facility. Employee 15 stated she was never trained on the facility's abuse prohibition policy prior to assuming her duties today. There was no documentation that Employee 15 (agency RN Supervisor) was trained on the facility's abuse prohibition policies and procedures as part of staff orientation and training on the prohibition of all forms of abuse, neglect, and exploitation prohibition. Interview with the interim Director of Nursing on March 30, 2024 at 11:15 a.m., confirmed the facility had no written records to show that Employee's 7 and 15 were trained on the facility's policy and procedures on as part of staff orientation and training before assuming job duties. 28 Pa. Code 201.20 (b) Staff development 28 Pa. Code 201.19 (7) Personnel policies and procedures