STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395357	A. Building B. Wing	04/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ellen Memorial Health Care Center	23 Ellen Memorial Lane Honesdale, PA 18431

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26142 Based on review of clinical records and select facility policy. facility investigative reports, and staff interviews, it was determined the facility failed to thoroughly investigate an incident of unknown origin to rule out abuse, neglect or mistreatment as the potential cause, for one out of 5 sampled residents (Resident 1). Findings include: A review of the facility's Abuse Policy, last reviewed by the facility in January 2025, indicated that incidents of unknown origin will be investigated as abuse until root cause can be identified. Written procedures for investigation include: identifying staff responsible for the investigation; exercising caution in handling evidence that could be used in a criminal investigation; investigating different types of alleged violations; identifying and interviewing all involved persons, including alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations; focusing the investigation on determining if abuse, neglect, exploitation, and/or mistreatment has occurred, the extent, and cause; and providing complete and thorough documentation of the investigation. A review of clinical record revealed Resident 1 was admitted to the facility on [DATE], with diagnoses which included diabetes and severe protein/calorie malnutrition. A review of an admission Minimum Data Set assessment (MDS - a federally mandated standardized assessment process completed periodically to plan resident care) dated January 21, 2025, revealed the resident was cognitively intact with a BIMS score of 13 (brief interview for mental status, a tool to assess the residents attention, orientation and ability to register and recall new information, a score of 13-15 equates to being cognitively intact) and requires staff assistance with activities of daily living (ADLs). A review of physician orders dated February 21, 2025, revealed an order for potassium chloride extended release, 10 MEQ tablets, four tablets by mouth, three times daily. A review of a February 2025 Medication Administration Record (MAR) revealed that nursing staff documented administration of all prescribed medications, including the potassium chloride, from February 21 through February 28, 2025 when he was transferred out to the hospital. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Nursing documentation dated February 28, 2025, at 11:52 AM indicated the resident's son requested hospital evaluation due to the resident feeling unwell, with symptoms of nausea and loose stools. The resident was noted to be incontinent of a small, pasty, tarry stool. He refused breakfast and morning medications. The abdomen was soft, non-tender, with positive bowel sounds. The physician evaluated the resident and ordered hospital transfer at approximately 11:40 AM. A review of hospital emergency room documentation dated February 28, 2025, indicated a CT scan (medical imaging procedure that uses X-rays to create detailed images of cross-sections of the body) of the abdomen and pelvis revealed innumerable circular foreign bodies. A rectal examination resulted in the expulsion of a copious amount of light brown, [NAME]/gritty liquid stool and 20-30 circular-shaped tablets, some with KC scoring, suspected to be potassium chloride. The emergency room physician documented a call with the attending physician, who stated uncertainty about whether nursing staff observed the resident swallow his oral medications. Nursing documentation dated February 28, 2025, at 8:02 PM revealed, Resident 1 was readmitted to the facility from the hospital with a diagnosis of foreign body in rectum. The hospital report included disimpaction (procedure to remove feces from the rectum) of more than 30 pills (multiple clusters). The resident denied inserting the medications into his rectum. Education was provided to the resident. There was no documented evidence the facility initiated an investigation upon the resident's return to identify the root cause of the unknown incident, including: interviews or witness statements from all staff members who had administered medications to Resident 1 during the period in question, an interview or written statement from the resident himself to assess potential mistreatment and a root cause determination to evaluate if abuse, neglect, or mistreatment may have occurred. On March 1, 2025, at 6:51 AM, nursing documentation revealed that staff entered the resident's room and observed multiple pills on the floor. The nursing supervisor was notified. A facility investigation report dated March 3, 2025, regarding the March 1, 2025, incident, documented that pills were found on the floor at the resident's bedside. The report stated the resident was known to have medications come out of his bowels. Witness statements from three employees dated March 3, 2025, (no time indicated) regarding the March 1 incident included: Employee 1 (LPN): Resident 1 always took his meds by mouth when I was the nurse. Employee 2 (LPN): Indicated the resident took his medications and was never observed attempting to insert them rectally. Employee 3 (RN): Noted the resident frequently refused medications; however, she waited bedside to ensure administration and never witnessed him placing medications in his rectum. There was no further documentation that staff responsible for medication administration from February 21-28 were interviewed or that any attempt was made to determine how the resident became impacted with more than 30 pills. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Additionally, there was no documented evidence that the facility interviewed Resident 1 regarding the incident to determine whether any staff had harmed him or administered medication inappropriately. An interview conducted with the Director of Nursing (DON) and the Nursing Home Administrator (NHA) on April 9, 2025, at 1:00 PM, confirmed that the facility failed to initiate a timely and comprehensive investigation into the February 28, 2025, incident to rule out abuse, neglect, or mistreatment. The facility failed to implement its own Abuse Policy requiring that incidents of unknown origin be investigated as potential abuse 28 Pa. Code 201.29(a)(c)(d) Resident rights 28 Pa. Code 201.14(a) Responsibility of Licensee 28 Pa. Code 201.18(e)(1) Management