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	12/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ellen Memorial Rehabilitation and Healthcare Cente	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 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** Based on review of clinical records, select facility policy and staff interview, it was determined the facility failed to timely notify the resident's responsible party of a change in condition for one resident out of 6 residents sampled (Resident 1). Findings include:A review of a facility policy for Change in condition last reviewed December 9, 2025, revealed, the purpose of the policy is to insure that the facility promptly informs the resident, consults the resident's Physician and notifies, consistent with his or her authority, the resident's representation when there is change requiring notification. Circumstances requiring notification to include, a transfer or discharge of the resident from the facility. A review of the clinical record revealed Resident 1 was admitted to the facility on [DATE], with diagnosis to include cerebral vascular disease (conditions affecting blood flow and bleeding in the brain), anxiety and high blood pressure. A review of Resident 1's quarterly minimum data set (MDS, a federally mandated standardized assessment conducted at specific intervals to plan resident care) dated September 16, 2025 revealed a BIMS score of 14 (BIMS, brief interview for mental status, a tool to assess the residents attention, orientation and ability to register and recall new information, a score of 14 to 15 equates to a cognitively intact resident). A review of Resident 1's clinical record, nursing documentation revealed that on November 21, 2025, at 9:06 PM, the resident was transferred to the hospital for evaluation and treatment. There was no evidence at the time of the survey that the residents responsible party was notified of the transfer to the hospital. An interview with the Director of Nursing and Nursing Home Administrator on December 10, 2025, at approximately 12:00 PM confirmed the facility failed to notify the resident's responsible party of the hospital transfer. Cross refer F 684, F770 28 Pa. Code: 201.14(a) Responsibility of licensee.28 Pa. Code: 201.18 (b)(1) Management.28 Pa. Code: 211.10 (c)(d) Resident Care policies 28 Pa. Code: 211.12 (d)(1)(2)(3)(5) Nursing services.

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

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	12/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ellen Memorial Rehabilitation and Healthcare Cente	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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (continued on next page)

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	12/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ellen Memorial Rehabilitation and Healthcare Cente	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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of clinical records, laboratory reports, intake documentation, facility records, and staff interviews, it was determined that the facility failed to provide the necessary care and services to ensure one resident (Resident 1) out of six residents reviewed, received timely assessment, monitoring, and intervention following a significant change in condition, including failure to ensure timely follow up of ordered diagnostic testing and failure to identify and address inadequate fluid intake. Findings include: According to the Pennsylvania Code, Title 49, Professional and Vocational Standards, State Board of Nursing, 21.11 (a)(1)(2)(4) indicates that the registered nurse was to collect complete ongoing data to determine nursing care needs, analyze the health status of individuals and compare the data with the norm when determining nursing care needs, and carry out nursing care actions that promote, maintain, and restore the well-being of individuals. The Pennsylvania Code, Title 49, Professional and Vocational Standards, State Board of Nursing, 21.145 Functions of the Licensed Practical Nurse (LPN) (a) The LPN is prepared to function as a member of the health-care team by exercising sound judgement based on preparation, knowledge, skills, understandings and past experiences in nursing situations. The LPN participates in the planning, implementation and evaluation of nursing care in settings where nursing takes place. 21.148 Standards of nursing conduct (a) A licensed practical nurse shall: (5) Document and maintain accurate records. A review of the clinical record revealed Resident 1 was admitted to the facility on [DATE], with diagnoses that included cerebral vascular disease (a condition affecting blood flow in the brain), anxiety, and hypertension (high blood pressure). A review of Resident 1's quarterly minimum data set (MDS, a federally mandated standardized assessment conducted at specific intervals to plan resident care) dated September 16, 2025 revealed a BIMS score of 14 (BIMS, brief interview for mental status, a tool to assess the residents attention, orientation and ability to register and recall new information, a score of 14 to 15 equates to cognitively intact resident).A review of nursing documentation dated November 7, 2025, revealed Resident 1 experienced a significant change in condition, including an elevated temperature of 103.2 degrees Fahrenheit and dysuria (pain with urination). Acetaminophen (Tylenol, a medication used to reduce fever) 650 mg by mouth was administered. At 5:41 AM, the resident's temperature remained elevated at 102.2 degrees Fahrenheit. The physician was notified and ordered a urinalysis (U/A, a test used to detect abnormalities in urine) and a urine culture and sensitivity (C&S, a test used to identify bacteria and determine appropriate antibiotic treatment). The specimen was collected and sent to the laboratory. There was no evidence that the facility ensured the results of the urinalysis collected on November 7, 2025, were received, reviewed, or acted upon Nursing documentation dated November 10, 2025, revealed the laboratory notified the facility that two urine specimens with the resident's identification were processed with conflicting results and that an additional specimen was required. The physician reordered the U/A and C&S, and another specimen was collected and sent to the laboratory. There was no evidence that the facility ensured timely completion of the reordered testing. A review of urinalysis results dated November 11, 2025, revealed yellow, cloudy urine with 3+ protein, 3+ leukocyte esterase (an enzyme produced by white blood cells that typically indicate infection), greater than 50 red blood cells per high power field, bacteria, and mucus, findings consistent with a urinary tract infection.Despite abnormal findings and persistent fevers, there was no evidence the facility ensured timely receipt of the culture and sensitivity results needed to guide treatment.Resident 1's temperature dated November 17, 2025, at 3:17 AM was documented as 101.6 degrees Fahrenheit, and the resident was administered acetaminophen 650 mg by mouth for the increased temperature.Nursing documentation dated November 17, 2025, at 3:58 PM revealed the laboratory had not completed the culture and sensitivity ordered on November 10, 2025, seven days after the order was placed. At that time, the physician was notified and reordered a urinalysis and culture and sensitivity. The documented nursing assessment indicated the resident's cheeks were pink, the resident reported she did not feel well, and her temperature was documented as 104 degrees Fahrenheit. Nursing documentation dated November 18, 2025, at 9:13 AM revealed the physician was again notified regarding the resident's condition. Additional orders were obtained for a urinalysis and culture and sensitivity, as well as laboratory studies including a complete blood count (CBC, a blood test that measures infection and inflammation markers) and a comprehensive metabolic panel (CMP, a blood test that measures kidney function and electrolyte balance). The urinalysis and culture and sensitivity were collected and sent to the laboratory, representing the third urine specimen collected for

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	12/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ellen Memorial Rehabilitation and Healthcare Cente	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 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. (continued on next page)

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	12/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ellen Memorial Rehabilitation and Healthcare Cente	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 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of clinical records, laboratory reports, physician orders, and staff interviews, it was determined that the facility failed to ensure laboratory services were provided in a timely manner and failed to ensure appropriate follow up of ordered laboratory testing for one resident (Resident 1) out of the six residents sampled (Resident 1). Findings included: A review of the clinical record revealed Resident 1 was admitted to the facility on [DATE], with diagnosis to include cerebral vascular disease (conditions affecting blood flow and bleeding in the brain), anxiety and high blood pressure. A review of Resident 1's quarterly minimum data set (MDS, a federally mandated standardized assessment conducted at specific intervals to plan resident care) dated September 16, 2025 revealed a BIMS score of 14 (BIMS, brief interview for mental status, a tool to assess the residents attention, orientation and ability to register and recall new information, a score of 14 to 15 equates to cognitively intact resident). A review of nursing documentation dated November 7, 2025, at 7:19 AM, revealed Resident 1 had an elevated temperature of 102.2 degrees Fahrenheit and dysuria (pain with urination). The physician was notified and ordered a urinalysis (U/A, a test used to detect abnormalities in urine) and a urine culture and sensitivity (C&S, a test used to identify bacteria and determine appropriate antibiotic treatment). The specimen was collected and sent to the laboratory. The specimen was collected and sent to the laboratory. There was no evidence at the time of the survey that results of the urinalysis were received or reported to the facility.Nursing documentation dated November 10, 2025, at 6:45 AM revealed facility staff received a telephone call from the laboratory indicating two urine specimen tubes bearing the resident's identification had been processed with conflicting results. The laboratory advised that an additional specimen was required to obtain accurate results.The physician was notified and reordered the urinalysis and culture and sensitivity. The specimen was collected and sent to the laboratory on November 10, 2025. Nursing documentation dated November 17, 2025, at 3:58 PM revealed the culture and sensitivity ordered on November 10, 2025, had not been completed seven days later. At that time, the physician was notified and ordered another urinalysis and culture and sensitivity. The nursing assessment documented the resident's cheeks were pink, the resident reported she did not feel well, and her temperature was noted to be 104 degrees Fahrenheit.Nursing documentation dated November 18, 2025, at 9:13 AM revealed the physician was again notified regarding the resident's condition. Additional laboratory testing was ordered, including a urinalysis, culture and sensitivity, a complete blood count (CBC, a blood test that measures components of the blood such as white blood cells to identify infection), and a comprehensive metabolic panel (CMP, a blood test that evaluates kidney function and electrolyte balance). The urinalysis and culture and sensitivity were collected and sent to the laboratory, representing the third urine specimen collected for processing.A review of laboratory results received at the facility on November 18, 2025, at 4:15 PM revealed abnormal findings, including a blood urea nitrogen (BUN, a blood test that measures the amount of urea nitrogen in the blood and is commonly used to assess how well the kidneys are functioning) level of 41 mg/dL (normal range 9 to 23 mg/dL), a creatinine level of 2.03 mg/dL (creatinine is a waste product filtered by the kidneys, and elevated levels indicate reduced kidney function; normal range 0.55 to 1.30 mg/dL), and a white blood cell count of 25.8 x103/uL (normal range 3.2 to 10.6 x103/uL), indicating significant infection and impaired kidney function.The resident was started on intravenous fluids, one half normal saline at 70 cubic centimeters per hour, and transferred to the hospital for evaluation and treatment, where she remained hospitalized for seven days with a diagnosis of acute kidney injury.There was no evidence at the time of the survey that the culture and sensitivity specimen submitted on November 10, 2025, was completed or that results were reported to the facility in a timely manner. There was also no evidence the facility ensured follow up with the laboratory when the ordered culture and sensitivity results were not received.During an interview conducted December 10, 2025, at approximately 2:00 PM, the Director of Nursing was informed of the survey findings related to laboratory services. The Director of Nursing reviewed the findings presented and was unable to provide documentation demonstrating timely follow up with the laboratory regarding the delayed culture and sensitivity results. 28 Pa. Code 211.12 (3)(5) Nursing services.