

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395357	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/15/2024
NAME OF PROVIDER OR SUPPLIER Ellen Memorial Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48276</p> <p>Based on a review of select facility policy, clinical records and select investigative reports, and resident and staff interviews, it was determined that the facility failed to ensure that three residents out of the five sampled for abuse (Residents 65, 73, and 89) were free from physical abuse.</p> <p>Findings include:</p> <p>A review of facility policy entitled Abuse, Neglect, and Exploitation, last revised by the facility on January 16, 2024, revealed that it is the policy of the facility to provide protections for the health, welfare, and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation, and misappropriation of resident property. The policy defines physical abuse as including, but not limited to, hitting, slapping, punching, biting, and kicking.</p> <p>Review of the clinical record revealed that Resident 73 was admitted to the facility on [DATE], with diagnoses of alcohol-induced persisting 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 related to the consumption of alcohol).</p> <p>A review of a quarterly Minimum Data Set assessment (MDS - a federally mandated standardized assessment process conducted periodically to plan resident care) dated April 14, 2023, revealed that Resident 73 was severely cognitively impaired.</p> <p>Clinical record review revealed that Resident 74 was admitted to the facility on [DATE], with a diagnosis of Alzheimer's disease (a brain disorder that slowly destroys memory and thinking skills and, eventually, the ability to carry out the simplest tasks). The resident's quarterly MDS assessment dated [DATE], revealed that Resident 74 was severely cognitively impaired.</p> <p>Resident 74's care plan noted that the resident displayed socially inappropriate behaviors that included hitting, punching, and swinging at staff initiated on April 11, 2023, with planned interventions to encourage the resident to interact with others and participate in activities of interest and encouraging the resident to express any feelings, fears, needs, or concerns as able.</p> <p>(continued on next page)</p>

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: 395357	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/15/2024
NAME OF PROVIDER OR SUPPLIER Ellen Memorial Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The resident's care plan also noted that Resident 74 has the potential to be verbally and physically aggressive toward staff related to dementia initiated October 18, 2022, with planned interventions to anticipate the resident's needs, provide physical and verbal cues, and providing the resident with as many choices as possible about care and activities.</p> <p>A record review revealed a Documentation Survey Report dated April 2023, indicating that Resident 74 displayed physical aggression towards others on April 2, 11, 15, and 16, 2023. The report indicated that Resident 74 threatened others on April 2, 9, 11, 15, and 16, 2023. The report also indicated that the resident hit and kicked others on April 2, 15, and 16, 2023.</p> <p>A review of clinical records and investigative reports, and staff interviews revealed that Resident 74 grabbed and scratched Resident 73's left forearm on May 10, 2024.</p> <p>A facility witness statement dated May 10, 2023 revealed that Employee A1, Nurse Aide witnessed Resident 74 attempting to push Resident 73's wheelchair. Employee A1 indicated that Resident 74 grabbed and scratched Resident 73 before staff could intervene.</p> <p>A progress note dated May 10, 2023, at 13:51 PM indicated that Resident 74 scratched another resident {Resident 73}. The entry indicated that Resident 74 sustained no injuries during the incident. However, a progress note dated May 11, 2023, at 14:26 (2:26 PM) revealed that Resident 73 sustained a scratch to her left forearm with linear scabbed areas and ecchymosis (bruising) measuring 6.0 cm x 0.5 cm. There was no redness, swelling, or drainage noted. The note indicated that Resident 73 had no complaints of pain in the area.</p> <p>During an interview on March 15, 2024, at approximately 10:15 AM, the Nursing Home Administrator (NHA) and Director of Nursing (DON) confirmed that the Resident 73 was not free from physical abuse perpetrated by Resident 74 resulting in a scratch and bruising on her left forearm.</p> <p>A clinical record review revealed that Resident 65 was admitted to the facility on [DATE], with diagnoses to 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 a quarterly MDS assessment dated [DATE], revealed that Resident 65 was severely cognitively impaired.</p> <p>A facility Report of Resident Aggression form dated February 15, 2024, revealed that Employee A2, a nurse aide, witnessed Residents 65 and 74 talking in the hallway. Employee A2, indicated that Resident 74 slapped Resident 65's face. Resident 65 grabbed Resident 74's hands and yelled out in response. Employee A2 explained that the residents were separated and calmed down.</p> <p>A progress note dated February 15, 2024, at 4:00 PM in Resident 65's clinical record, revealed that staff observed another resident, Resident 74, slap Resident 65 on the left side of her face. Resident 65 had no complaints of pain or discomfort and was assessed without redness, edema, or bruising to the left side of her face.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395357	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/15/2024
NAME OF PROVIDER OR SUPPLIER Ellen Memorial Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A progress note dated February 15, 2024, at 9:06 PM in Resident 74's clinical record revealed that a nurse aide reported Resident 74 had smacked another resident {Resident 65} in the face. The note indicated that the residents were immediately separated, and Resident 74 had no complaints of pain or distress. The entry indicated that Resident 74 continued to display increased poor impulse control with behaviors such as wandering into resident rooms and pushing residents in wheelchairs. The progress note explained that distraction activities were provided and effective for brief periods of time.</p> <p>During an interview on March 15, 2024, at approximately 10:15 AM, the Nursing Home Administrator (NHA) and Director of Nursing (DON) confirmed that the facility failed to protect Resident 65 from physical abuse.</p> <p>A clinical record review revealed that Resident 89 was admitted to the facility on [DATE], with diagnoses that included heart failure (a condition that develops when the heart doesn't pump enough blood to meet the body's needs). A quarterly MDS assessment indicated that Resident 89 was moderately cognitively impaired.</p> <p>A clinical record review revealed that Resident 80 was admitted to the facility on [DATE], with diagnoses that included dementia. A significant change in status MDS assessment dated [DATE], revealed that Resident 80 was severely cognitively impaired.</p> <p>A review of Resident 80's current care plan revealed that he has a problem with impaired cognitive functions, impaired thought processes, and impulse control related to his diagnosis of dementia, initiated on September 3, 2023. Care plan interventions planned were cueing, reorienting, and supervising as needed; engaging the resident in simple, structured activities; and providing a program of activities that accommodates the resident's abilities.</p> <p>The resident's Documentation Survey Report dated January 2024, indicated that Resident 80 displayed agitation on January 1 and 3, 2024. The resident was cursing at others, frustration directed at others, displayed aggression towards others on January 1, 3, and 4, 2024, and the resident was entering other resident rooms on January 3, 2024.</p> <p>A review of clinical records and investigative reports revealed that Resident 80 pushed and hit Resident 89 with a reaching-assistance device on January 10, 2024.</p> <p>A witness statement dated January 10, 2024, provided by Employee 2, Licensed Practical Nurse, indicated that Resident 89 was at his bedroom door, yelling to get this man {Resident 80} out of his room. Resident 80 was found in Resident 89's bathroom. Resident 80 was agitated and putting his fist up. Employee 2 indicated that she was able to redirect Resident 80 out of Resident 89's room. Employee 2 reported that Resident 89 informed her that Resident 80 went through his belongings, shoved him, and then hit him with a grabber {reaching-assist device}.</p> <p>A progress note dated January 10, 2024, at 10:30 PM indicated that Resident 89 was on the phone with his family member when Resident 80 entered Resident 89's bedroom. Resident 89's family member called the facility to report the incident, at which time Employee 2, LPN, responded to Resident 89's room. The note indicated that Resident 80 went through Resident 89's personal belongings, shoved him in the left shoulder, and hit him on the left hand with a grabber bar {reaching-assist device}. The note indicated that Resident 89 had no complaints of pain or injuries noted.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395357	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/15/2024
NAME OF PROVIDER OR SUPPLIER Ellen Memorial Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A progress note dated January 10, 2024, at 10:28 PM indicated that Resident 80 was wandering into rooms and agitated with another male resident. The note indicated that Resident 80 had no symptoms of pain or discomfort, care was provided, and the resident appeared pleasant and cooperative.</p> <p>A physician note dated January 11, 2024, at 9:53 PM indicated that Resident 89 was seen today due to being accosted yesterday by another resident with a long shoehorn {reaching-assist device} and a tissue box. Resident 89 complained of left shoulder pain after being hit there with the long shoehorn.</p> <p>During an interview on March 12, 2024, at 10:10 AM, Resident 89 indicated that a while back, a gentleman entered his room. He explained that he told the resident to leave, but he wouldn't listen. Resident 89 stated that the resident pushed him and hit him on the shoulder. He explained that he had some pain in the shoulder the next day, but it has healed since the incident. During the interview, Resident 89 explained that the incident doesn't bother him, because he believes that the other resident didn't know what he was doing.</p> <p>During an interview on March 15, 2024, at approximately 10:15 AM, the Nursing Home Administrator (NHA) and Director of Nursing (DON) confirmed that the facility failed to protect Resident 89 from physical abuse.</p> <p>Refer to F744</p> <p>28 Pa. Code 201.14(a) Responsibility of licensee</p> <p>28 Pa. Code 201.18(e)(1) Management</p> <p>28 Pa. Code 201.29 (a)(c) Resident Rights</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395357	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/15/2024
NAME OF PROVIDER OR SUPPLIER Ellen Memorial Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41460</p> <p>Based on review of clinical records and the facility's abuse prohibition policy and staff interview, it was determined that the facility failed to implement their established procedures for thoroughly investigating an injury of known source, a fractured leg, sustained by one resident, to rule out abuse, neglect or mistreatment as the potential cause for out of 21 residents sampled (Resident 57).</p> <p>Findings include:</p> <p>A review of the facility's Abuse Policy, last reviewed by the facility on January 16, 2024, 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.</p> <p>According to the policy an Injury of Unknown Source includes circumstances when both the following conditions are met; the source of the injury was not observed by any person or could not be explained by the resident; and the injury is suspicious because of the extent of the injury, location of the injury, the number of injuries observed at one particular point in time, or the incidence of injuries over time.</p> <p>Review of clinical record revealed Resident 57 was admitted to the facility on [DATE], with diagnoses, which included dementia, chronic obstructive pulmonary disease, and hypertension.</p> <p>Review of a Quarterly MDS assessment dated [DATE], revealed that Resident 57 was severely cognitively impaired and required staff assistance to perform activities of daily living to include toileting, transfers, and walking in/out of room.</p> <p>Review of documentation dated January 22, 2024, at 7:05 p.m. revealed a Change in Condition report which indicated that the resident's right ankle was red, tender to touch and movement, and the resident was yelling out when ankle was moved.</p> <p>Review of documentation dated January 22, 2024, at 7:20 p.m. revealed that the physician ordered an x-ray of the resident's right foot and ankle.</p> <p>Review of X-ray results revealed that osteoarthritic changes are seen, the bones are osteopenic (bones are weaker than usual, which increases risk of developing osteoporosis and fractures), and there is an acute fracture of the distal tibia and fibula (fracture that occurs at the lower/ankle end of the leg) with soft tissue swelling noted. The resident was sent to the emergency room for evaluation and returned with a splint in place to right ankle.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395357	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/15/2024
NAME OF PROVIDER OR SUPPLIER Ellen Memorial Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of facility's investigation dated January 22, 2024, at 7:10 p.m. revealed that Resident 57 was yelling out when the right leg was touched or moved.</p> <p>Review of witness statement dated January 22, 2024, completed by Employee 6, nurse aide, revealed that while caring for Resident 57 during her scheduled shift of 3 p.m. to 5 a.m. on January 21, 2024, into January 22, 2024, the resident was fine. According to Employee 6, on January 21, 2024, she took the resident for her scheduled shower, and was assisted by Employee 9, nurse aide, to use mechanical lift to place resident in shower chair. After providing the shower, Employee 6 was then assisted again by Employee 9 with mechanical lift to place resident in her chair, and in dining room for dinner. On January 22, 2024, Employee 6 stated that she was assisted by Employee 5, licensed practical nurse, to use mechanical lift and get resident up to brush her teeth and I put [her] by TV and went home.</p> <p>Review of witness statement dated January 22, 2024, completed by Employee 5, LPN, revealed that she assisted Employee 6 with mechanical lift to get Resident 57 out of bed that morning. According to statement, resident was normal self, no complaints of pain or discomfort noted. When I left room, Employee 6 was setting resident up to brush her teeth.</p> <p>Review of an additional witness statement from Employee 6 dated January 22, 2024, revealed that when Employee 6 came in at 4 p.m. on January 22, 2024, the resident was seated in the little dining room watching television. After dinner, Employee 7, a nurse aide, assisted putting the resident to bed. As soon as we lifted her she started yelling her foot, so I tried to see if I could help her after we hot her to bed and you could not even touch her foot so I went and got the nurse.</p> <p>There was no documented evidence that the facility interviewed additional staff members, including those from the other shifts that cared for the resident prior to the injury, including Employee 9. There was no evidence that the facility investigated potential causes of injury that may have occurred from 7 a.m. to 4 p.m. on January 22, 2024, or that the facility attempted to gather additional information that may have contributed to the resident sustaining a fracture to her leg.</p> <p>Interview with the Director of Nursing (DON) on March 14, 2024, at approximately 11 a.m. indicated following the identification of the resident's injury the facility planned to educate staff on the use of the mechanical lift, which included return demonstrations to rule out potential staff technique as a potential cause of injury to the resident. The DON confirmed that there was no documented evidence that the education was provided, however, at the time of the survey ending March 15, 2024.</p> <p>Interview with the Director of Nursing on March 14, 2024, at approximately 11:00 a.m. confirmed that the facility failed to provide evidence of a thorough investigation conducted into the resident's serious injury of unknown origin to rule out abuse, neglect or mistreatment.</p> <p>28 Pa. Code 201.14 (a) Responsibility of Licensee</p> <p>28 Pa. Code 201.18 (e)(1) Management</p> <p>28 Pa. Code 201.29 (a)(c) Resident rights</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395357	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/15/2024
NAME OF PROVIDER OR SUPPLIER Ellen Memorial Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide activities to meet all resident's needs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48276</p> <p>Based on observation, a review of clinical records and schedule of activities programming and resident activities participation records, and resident and staff interviews, it was determined that the facility failed to provide an ongoing program of activities designed to meet the needs, interests, and functional abilities of residents, including three residents out of 21 sampled (Residents 77, 74, and 80).</p> <p>Findings include:</p> <p>A clinical record review revealed that Resident 74 was admitted to the facility on [DATE], with diagnoses that included Alzheimer's disease (a brain disorder that slowly destroys memory and thinking skills and, eventually, the ability to carry out the simplest tasks).</p> <p>A quarterly Minimum Data Set assessment (MDS - a federally mandated standardized assessment process conducted periodically to plan resident care) dated January 16, 2024, revealed that Resident 74 is severely cognitively impaired.</p> <p>Resident 74's care plan, included the problem of socially inappropriate behaviors that included hitting, punching, and swinging at staff initiated April 11, 2023. Planned interventions were to encourage the resident to interact with others, participate in activities of interest, encourage the resident to express any feelings, fears, needs, or concerns as able.</p> <p>Resident 74's care plan also identified that the resident had the potential to be verbally and physically aggressive towards staff related to dementia dated October 18, 2022. Planned interventions were to anticipate the resident's needs, providing physical and verbal cues, and providing the resident with as many choices as possible about care and activities.</p> <p>Resident 74's care plan identified that the resident had a preference for activities that include gardening, time outdoors, watching Jeopardy, Hallmark Channel movies, and Classic movies, listening to others reading, hymns, and crafting.</p> <p>A review of Resident 74's activities participation revealed no documented evidence that the facility had provided, or the resident had participated in the preferred activities. Resident 74's activities participation records for December 2023, January 2024, and February 2024 revealed that she participated in only three reading activities. There was no indication of how many reading activities were offered to the resident. It was not identified if the resident was reading or other were reading to the resident. There was no indication that Resident 74 was provided an opportunity to watch Hallmark Channel movies, classic movies, or the Jeopardy television game show. There was no indication that Resident 74 was provided the opportunity to participate in a crafts program in February 2024.</p> <p>Resident 74's activities participation records for December 2023, January 2024, and February 2024, revealed that the resident was wandering during 10 activities opportunities and in bed during 22 activities opportunities. There was no evidence that Resident 74 was encouraged, prompted, or directed to the available activities programming on those dates.</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395357	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/15/2024
NAME OF PROVIDER OR SUPPLIER Ellen Memorial Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A review of Resident 74's activities participation records for December 2023, January 2024, and February 2024, revealed no evidence of the resident's level of participation, duration of participation in the activities and the resident's response to any programming provided to evaluate the adequacy and appropriateness of the activities programming provided to this resident.</p> <p>A review of Resident 77's clinical record revealed that she was admitted to the facility on [DATE], with diagnoses that included unspecified dementia, dysphagia, aphagia (inability to speak), anxiety disorder and was severely cognitively impaired.</p> <p>The resident's care plan, dated January 18, 2022, and revised December 19, 2023, identified that the resident displayed socially inappropriate behaviors, of rummaging through other resident's belongings, disrobing in public, voiding/defecating in inappropriate areas, physical and verbal aggression, calling anyone near her [NAME]/[NAME] and looking for husband [NAME] and pushing other residents. Resident 77's goal was to not exhibit socially inappropriate behaviors with planned interventions to encourage the resident to interact with others as able, enjoy small groups such as sing-a-longs and Rosary. Resident 77's plan of care indicated that the resident was at risk for wandering and had the potential to become physically/verbally aggressive towards staff and others related to dementia. Planned interventions to manage these behaviors were to distract the resident from wandering by offering pleasant diversions such as structured activities (not specified), food, conversation (topic not identified), television (viewing preference not identified), warm tea, reminiscing (topic not identified), looking through old pictures (location of these photographs), and memory boxes. Planned interventions to manage the resident's dementia related behaviors also included providing independent activities such as folding and organizing clothes and sensory activities such as light shows with music.</p> <p>A review of Resident 77's activity participation logs dated October 2023, November 2023, December 2023, January 2024, February 2024, through survey ending March 15, 2024, revealed that the resident had limited periodic participation in activities such as coffee cart, small group activities (program not identified) in the AM and PM, arts and crafts, and outside.</p> <p>Observation of the facility's activities calendar posted on the wall in the Gold Unit on March 14, 2024, at 10:45 a.m., revealed the scheduled activities for the day included: Coffee Clutch at 9:00 a.m., One-to-Ones at 10:00 a.m., Sensory Time at 11:00 a.m., Chip 'N' Dips at 3:00 p.m., Balloon Battle from 4-6:00 p.m., and Music Time from 7-8:00 p.m.</p> <p>During an observation of the Gold Unit, the facility's dedicated dementia unit, on March 14, 2024, at approximately 10:45 a.m., revealed the doors to the activity room were closed. Upon entering the activity room, four residents were observed seated in their wheelchairs there was no activities program occurring at that time. The television was on, but the residents did not appear to be engaged in watching the television. At this time, Resident 77 was observed in another resident's room, room [ROOM NUMBER], laying on the other resident's bed near the door.</p> <p>Observation of the Gold Unit revealed that upon exiting the resident activity room, at approximately 11:04 a.m., nursing staff discovered that Resident 77 was in an another's resident's room and escorted her out. Resident 77 then entered the activity room, but not begin watching the television and instead began to wander about the unit.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395357	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/15/2024
NAME OF PROVIDER OR SUPPLIER Ellen Memorial Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview with Employee 8, an activity staff member, on March 14, 2024, at 11:07 a.m., revealed that lunch would be coming shortly and that they were getting ready to set up the activity area. Employee 8 stated that staff were going to put a sing-along video that showed the words for the residents to follow along while they set up the room for lunch.</p> <p>The planned activity noted on the activity calendar for the Gold Unit at that time was, Sensory Time, but the source of the sensory stimulation was not identified</p> <p>A review of the schedule of the activities department staff for the months of January 2024, February 2024, and through survey ending March 15, 2024, revealed that the employees assigned to the Gold Unit worked the day shifts 9:00 a.m. to 5:00 p.m. and one employee that worked 2:00 p.m. to 7:00 p.m. once per month.</p> <p>During an interview with the facility's activities consultant on March 15, 2024, at 10:05 a.m., the employee stated that that the Gold Unit (dementia care unit) that the facility currently has a job openings on the evening shift and confirmed that the facility does not consistently have activities staff working during the evening shifts on the Gold Unit to provide diversional activities to manage escalating dementia behaviors that frequently occur during periods of sundowning in the late afternoon and early evening hours.</p> <p>The facility was unable to provide evidence that the facility had developed and implemented an individualized activities program to meet the resident's cognitive and functional abilities. The facility failed to accurately monitor the resident's activities participation and the resident's response to any activities programming provided to design an appropriate individualized program of activities to meet the resident's current needs and abilities.</p> <p>A clinical record review revealed that Resident 80 was admitted to the facility on [DATE], with a diagnosis of dementia. A significant change in status MDS assessment dated [DATE], revealed that Resident 80 is severely cognitively impaired.</p> <p>Resident 80's current care plan revealed that he has a problem with impaired cognitive functions, impaired thought processes, and impulse control related to his diagnosis of dementia, initiated on September 3, 2023. The planned interventions were to cue, reorient, and supervise the resident as needed, engaging the resident in simple, structured activities (not identified) and providing a program of activities that accommodates the resident's abilities.</p> <p>The resident's care plan revealed that he enjoys 50's and 60's music, word search, reading the newspaper, car magazines, spending time outdoors, socials, animals, kids, and assisting with bingo.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395357	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/15/2024
NAME OF PROVIDER OR SUPPLIER Ellen Memorial Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A review of Resident 80's activities participation records for the months of December 2023, January 2024, and February 2024, revealed no evidence that the facility had participated in the resident's preferred activities or was provided materials/resources for self-directed activities he preferred. Resident 80's activity participation records for December 2023, January 2024, and February 2024 revealed that he participated in one bingo activity. There was no indication of how many bingo opportunities were offered to Resident 80. The resident's participation records for December 2023, January 2024, and February 2024 revealed that the resident was wandering during three activity opportunities, napping during 35 activity opportunities, and refused 16 activities (not identified which were refused). The resident's activities participation records from December 2023 through the time of the survey ending March 15, 2024, revealed no evidence of the resident's level of participation, duration of participation in the activities and the resident's response to any programming provided to evaluate the adequacy and appropriateness of the activities programming provided to this resident.</p> <p>During an interview on March 15, 2024, at approximately 10:30 AM, the Nursing Home Administrator and Director of Nursing confirmed the facility failed to provide an ongoing program of activities designed to meet the needs, interests, preferences, and functional abilities of residents, including Residents 77, 74, and 80.</p> <p>28 Pa. Code 201.29 (a) Resident rights</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395357	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/15/2024
NAME OF PROVIDER OR SUPPLIER Ellen Memorial Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide enough food/fluids to maintain a resident's health.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41460</p> <p>Based on clinical record and select policy review and staff interview, it was determined that the facility failed to accurately monitor a fluid restriction prescribed to address a resident's clinical condition and maintain fluid balance and adequate hydration status for two residents out of 21 sampled. (Resident 35 and 43)</p> <p>Findings include:</p> <p>A review of a facility policy entitled Fluid Restrictions that was last reviewed by the facility on January 16, 2024, indicated that the facility would ensure that fluid restrictions would follow in accordance with physician's orders. Nursing will obtain and verify physician's orders for the fluid restriction and an order written to include the breakdown of the amount of fluid per 24-hours to be distributed between the food and nutrition department and the nursing department and will be recorded on the medication record or other format as per facility policy.</p> <p>A review of Resident 35's clinical record revealed that the resident was admitted to the facility on [DATE], with diagnoses that included heart failure [is a progressive heart disease that affects pumping action of the heart muscles that causes fatigue, shortness of breath] and hyponatremia [(low sodium lab value) is a condition where sodium levels in the blood are lower than normal and caused by too much water present in the body dilutes sodium levels and caused symptoms of confusion, muscle spasms, convulsions].</p> <p>A physician orders dated February 1, 2024, was dated for the resident to maintain a 1500 ml per day fluid restriction due to hyponatremia.</p> <p>The resident's nutritional plan of care revised by the registered dietitian (RD) on February 2, 2024, at 10:27 a. m., indicated that Resident 35 was nutritionally at risk due to hyponatremia with an intervention to maintain a 1500 ml per day fluid restriction. Planned interventions were for the dietary department to provide the following fluids at breakfast: decaf hot tea 6 oz- 180 cc, orange Juice- 4 oz- 120 cc, and milk- 8 oz- 240 cc for a total of 18 oz/540 cc at breakfast; lunch: decaf hot tea 6 oz- 180 cc, orange juice- 4 oz- 120 cc for a total of 12 oz/300 cc at lunch, and dinner decaf hot tea 6 oz- 180 cc, orange juice- 4 oz- 120 cc for a total 12 oz/300 cc at dinner. Total fluids from dietary on trays 1140 cc/day and allotted 360 cc of fluids to be provided by nursing staff to total 1500 cc per the MD orders.</p> <p>A review of Resident 35's clinical record Medication Administration Record [(MAR, or eMAR for electronic versions), commonly referred to as a drug chart, is the report that serves as a legal record of the drugs administered to a patient at a facility by a health care professional and is a part of a patient's permanent record on their medical chart] dated February 2024 and March through survey ending March 15, 2024, failed to reveal documented evidence that nursing staff recorded the amount of fluids nursing staff provided to the resident daily.</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395357	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/15/2024
NAME OF PROVIDER OR SUPPLIER Ellen Memorial Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A review of the resident's Documentation Survey Reports dated February 2024 and through survey ending March 15, 2024, failed revealed inconsistent documentation to demonstrate that the facility accurately recorded and/or accounted for the amount of fluids the resident consumed each day to assess compliance with physician ordered fluid restriction to treat the resident's clinical diagnosis of hyponatremia and heart failure and meet the resident's hydration needs.</p> <p>During an interview with the Director of Nursing (DON) and in the presence of the Nursing Home Administrator (NHA) on March 15, 2024, at 10:15 a.m., confirmed that the facility was unable to provide documented evidence that nursing staff documented the amount of fluids provided to Resident 35 daily and confirmed that the facility failed to ensure that staff consistently documented and monitored the resident's fluid intakes as required for maintenance of the physician ordered 1500 ml per day fluid to manage Resident 35's chronic conditions.</p> <p>A physician's order dated February 20, 2024, was noted for the resident to be maintained on a 2000 cc fluid restriction related to a diagnosis of congestive heart failure.</p> <p>Resident 43's care plan, initiated July 17, 2023, revealed that the resident has the potential for fluid overload or potential fluid volume overload related to disease process congestive heart failure. Interventions planned October 30, 2023, included that 1410 ml fluid provided by dietary on meal trays, and nursing staff provide at total of 410 ml fluids daily. The registered dietitian recommended 7 AM - 3 PM nursing staff offer/give 180 ml daily, 3 PM to 11 PM nursing staff offer/give 120 ml daily, and 11 PM to 7 AM nursing staff offer/give 110 ml daily. The care planned interventions were to monitor/document/report as needed any signs/symptoms of fluid overload: anorexia, mood/behavior changes, confusion, edema, nausea/vomiting, shortness of breath, difficulty breathing, increased respirations, difficulty breathing when lying flat, congestion, cough, fatigue, jugular venous distention, or sudden weight gain. The resident was to be weighed daily in the morning and ensure that all the resident's snacks and beverages offered at activities comply with diet and fluid restrictions.</p> <p>A review of the resident's February 2024 and March 2024 Documentation Survey Reports failed to provide evidence of an accurate recording and accounting of the amount of fluids the resident consumed each day to assess compliance with physician ordered fluid restriction and hydration needs.</p> <p>Review of clinical documentation completed by Registered Dietitian February 20, 2024 through March 7, 2024, failed to provide evidence that Resident 43's physician ordered fluid restriction was monitored for compliance with the prescribed 2000 ml restriction and that the resident's fluid intake was adequate to maintain hydration.</p> <p>An interview with the Director of Nursing on March 15, 2024, at 1:15 p.m., confirmed that the facility failed to total and calculate resident's daily fluid intake to confirm the amount of fluid consumed by the residents' daily, compliance with the physician prescribed fluid restriction and adequacy for hydration needs.</p> <p>28 Pa. Code: 211.12 (c)(d)(3)(5) Nursing services</p> <p>28 Pa. Code 211.5(f) Medical records</p> <p>28 Pa. Code 211.10 (a)(c)(d) Resident care policies</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395357	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/15/2024
NAME OF PROVIDER OR SUPPLIER Ellen Memorial Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0740</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident must receive and the facility must provide necessary behavioral health care and services.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41460</p> <p>Based on review of select facility policies and clinical records, staff and resident interview it was determined that the facility failed to provide necessary behavioral health care to promote the highest practicable physical and psychosocial well-being of one resident out of 21 sampled (Resident 5).</p> <p>Findings include:</p> <p>A review of facility policy entitled Behavioral Management last reviewed January 16, 2024, indicated that residents who exhibit behaviors which could endanger themselves, other residents or staff may benefit from a behavioral care plan to ensure they are receiving appropriate services and interventions to meet their needs. Behaviors should be documented clearly and concisely by facility staff and documentation should be specific behaviors, time and frequency of behaviors, observations of what may be triggering behaviors, what interventions were utilized and the outcomes of the interventions. Behaviors should be identified and approaches for modification or redirection should be included in the comprehensive plan of care. Facility efforts to help residents with mental disorder such as individual counseling services, access to group counseling, or access to a medication assisted treatment program if applicable.</p> <p>Review of the clinical record revealed that Resident 5 was admitted to the facility on [DATE], and had diagnoses, which included post-traumatic stress syndrome ([PTSD] a mental condition that develops following a traumatic event characterized by intrusive thoughts, recurrent distress/anxiety, flashback, and avoidance of similar situations), anxiety and depression.</p> <p>A quarterly Minimum Data Set assessment ([MDS] a federally mandated standardized assessment process completed at specific intervals to plan resident care) dated February 1, 2024, indicated that Resident 5 had a BIMS (brief screener that aids in detecting cognitive impairment) score of seven indicating the resident was severely cognitively impaired and required assistance of staff for activities of daily living (ADL).</p> <p>The resident's care plan initially dated December 2, 2022, indicated that the resident has the potential to be verbally and physically aggressive toward staff and others. The planned interventions were to analyze the times of day, places, circumstances, triggers and what de-escalates the behavior and document, assess and address contributing sensory deficits and any needs the resident may have, communicate by providing physical and verbal cues to alleviate anxiety, give positive feedback, encourage seeking out staff when agitated, give the resident as many choices as possible about care and activities, and psychiatric/psychogeriatric consultation as indicated.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395357	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/15/2024
NAME OF PROVIDER OR SUPPLIER Ellen Memorial Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0740</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The resident's care plan dated December 27, 2022, identified alterations in behavior as evidenced by socially inappropriate behavior by disruptive sounds yelling out/cursing/hoarding items, smearing, or throwing food/coffee cups or feces, hitting staff, taking a pair of pliers out of a drawer under the fish tank and hiding them under the blanket, infatuated with female staff and turning lights off in the hallways. The resident's care plan was revised on February 9, 2024, with planned interventions to approach the resident slowly and calmly, remind that yelling is disruptive and upsetting to the other residents. If behavior is unacceptable, remove the resident from the public area, monitor for patterns or triggers to problem behavior, offer a snack or drink, 1:1 visit encouraging the resident to express his feelings, fears, concerns or needs and provide emotional support and reassurance.</p> <p>The resident's care plan did not identify the interventions planned to attempt to determine the root cause of the resident's behaviors or the interventions developed for staff to employ when the resident exhibits these behavioral symptoms.</p> <p>The resident's care plan initially dated March 21, 2023, indicated that the resident had trauma as evidenced by PTSD related to the Korean War and more recently concerns related to the Ukrainian War, as his daughter lives there and her location was bombed. The planned interventions, initiated March 23, 2023, noted the resident's triggers, being getting easily startled by loud noises, with coping mechanisms to play cards and involve family as needed, offer consultation with the social worker, time to verbalize feelings as needed, and provide emotional support and conversation in a non-judgmental tone.</p> <p>As of the time of the survey ending March 15, 2024, there was no evidence of any review of this plan for continued adequacy and effectiveness in meeting the resident's mental health care needs.</p> <p>Review of a Psychiatric Progress Note dated March 29, 2023, indicated that Resident 5 had been getting more anxious and depressed, talking about not wanting to be in the facility, easily annoyed and irritable. Resident denies having suicidal thoughts and states I could be better. The plan was to continue Trazodone (antidepressant medication) 25 milligrams (mg) at night and increase Paxil (antidepressant medication) to 20 mg in the morning for unspecified depressive disorder and continue to monitor and provide support.</p> <p>There was no documented evidence that Resident 5 was provided and further follow-up psychiatric services treatment between March 29, 2023, through the time of the survey ending March 15, 2024.</p> <p>A review of nurse's notes from the months of December 2023, January 2024, February 2024, and March 2024 revealed that the resident routinely refused care and treatment, including medications becoming verbally aggressive yelling and cursing at staff when attempts were made to encourage and redirect the resident.</p> <p>A nurses note dated December 13, 2023, at 9:23 PM revealed that the resident was refusing to shower or remove urine saturated clothing. The resident was unreceptive to education that staff provided. After several attempts the resident was agreeable to removing soiled clothing and bed linens.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395357	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/15/2024
NAME OF PROVIDER OR SUPPLIER Ellen Memorial Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0740</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A nurses note dated December 26, 2023, at 10:51 PM revealed that the resident was in the blue dinette and grabbed another resident's animatronic cat and threw it across the room, breaking the leg. When the resident was asked why he would damage another resident's personal belonging, the resident stated, I don't like him, and I don't like the cat and I don't give a f*ck that its broke. The entry noted that the Nursing Supervisor was made aware.</p> <p>A nurses note dated January 16, 2024, at 3:34 PM revealed that the resident was refusing Glargine (insulin medication) coverage of 25 units and stated get out of here, I said get out of here and I am not going to tell you again. The resident then flipped off his middle finger in the air as a derogatory gesture to the nurse. The nurse attempted to provide emotional support, but noted that the resident is difficult to redirect and reapproach at this time, again the Nursing Supervisor was made aware.</p> <p>Review of Documentation Survey Report v2 titled behavior monitoring and interventions for February 2024, revealed that the resident displayed behaviors of being physically aggressive towards others, cursing at others, agitated and anxious, neglecting self and refusing care on the following dates February 2, 9, 18, 19, 21, 22, 23, 26, 28, 29, 2024. Interventions documented were to reapproach and redirect the resident with the same unchanged behavior or worsened behavior and no revisions to the interventions planned for staff to employ when the resident displayed these behaviors. On February 18, 2024, at 9:21 PM the resident was cursing and became physically aggressive toward others with no intervention (NI) documented.</p> <p>A nurses note dated February 8, 2024, at 4:01 PM, revealed the resident was having increased behaviors at this time. Staff reported that the resident was refusing his (safety) alarms and demanding staff get out of his room. Again the Nursing Supervisor was made aware.</p> <p>A nurses note dated February 13, 2024, at 10:50 PM, revealed that resident was verbally aggressive to female staff members during this shift.</p> <p>A plan of care note dated February 23, 2024, at 12:10 PM revealed psychotropic medication review was completed and the interdisciplinary team including the resident's representative agreed that the resident has been stable on current dose of Paxil 30 mg daily. The resident's Trazodone was discontinued on October 26, 2023. The entry noted that the resident has a history of PTSD from the war and recent episodes he was involved in the Ukraine war. The increase in the Paxil dosage has improved his mood and sleeping habits and a gradual dose reduction at this time would cause additional distress.</p> <p>A nurses note dated February 29, 2024, at 4:53 PM revealed that the resident was observed by staff instigating arguments with other residents, causing arguments between them and would laugh when the other residents would begin to yell.</p> <p>Review of Documentation Survey Report v2 titled behavior monitoring and interventions for March 2024, revealed that the resident displayed behaviors of grabbing others, neglecting self, refusing care, and appeared withdrawn/isolating on the following dates March 3, 4, 6, 7, 9, 2024. Interventions documented were to reapproach and redirect the resident with the same unchanged behavior and no revisions or additions to the interventions planned to address those behaviors.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395357	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/15/2024
NAME OF PROVIDER OR SUPPLIER Ellen Memorial Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0740</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>There was no documented evidence that the facility had developed and implemented an interdisciplinary approach to the resident's care, with qualified staff that demonstrate the competencies and skills necessary to provide appropriate services to the resident, individualized approaches to care, including direct care and activities provided to support the resident's physical, mental, and psychosocial environment, and are directed toward understanding, preventing, relieving, and/or accommodating a resident's distress.</p> <p>There was no documented evidence that the facility had provided the resident with timely and necessary behavioral health care to address the resident's increased behavior's and had reviewed and revised the planned interventions that proved ineffective.</p> <p>A nurses note dated March 12, 2024, at 1:57 PM revealed that a new order was noted to discontinue Paxil 30 mg daily and begin Paxil 20 mg by mouth daily for depression.</p> <p>Observations of Resident 5 throughout the days of the survey March 12, 2024, and March 13, 2024, revealed that the resident spent the majority of time when observed sleeping in his bed.</p> <p>Interview with Employee 1 Licensed Practical Nurse (LPN) on March 14, 2024, at approximately 10:35 AM revealed that Resident 5 has not had many issues on day shift (7:00 AM - 3:30 PM), that the resident will occasionally refuse care but has not had any aggressive behaviors, but is aware that the resident has increased behaviors frequently during other shifts of nursing duty.</p> <p>Interview with Resident 5 on March 14, 2024, at 11:03 AM, revealed that the resident was sitting on his bed in his room. The resident was smiling, when approached by the surveyor. The resident, who was very hard of hearing, was asked how he was and about the care he was receiving. The resident replied yes I have a lot {of complaints}, but who really cares and would not further elaborate to the surveyor. When asked how he was sleeping, and preferred sleep schedule, the resident stated that he sleeps on and off, mostly sleeps during the day. When discussing preferred or desired activities, he laughed and said, what activities?, he stated that he would like to be able to go outside once in a while, but does not enjoy bingo games. Resident 5 then made an inappropriate comment, of a sexual nature, directed at the female surveyor, and then declined to answer any further questions.</p> <p>Interview with Nursing Home Administrator (NHA) on March 14, 2024, at 12:00 PM revealed that Resident 5 is part of morning report during which staff discuss behaviors on almost a daily basis.</p> <p>Interview with the Nursing Home Administrator (NHA) on March 15, 2024, at approximately 1:00 PM, revealed that the facility was unable to provide evidence that the facility had provided, or obtained from outside resources, the necessary care and services to meet the resident's behavioral health needs.</p> <p>28 Pa Code 211.12 (d)(3)(5) Nursing Services</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395357	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/15/2024
NAME OF PROVIDER OR SUPPLIER Ellen Memorial Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0744</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43944</p> <p>Based on a review of clinical records, select facility policy and facility incident reports, observations, and staff interviews, it was determined that the facility failed to provide the necessary treatment and services to maintain the highest practicable level of mental, physical and psychosocial well being of three residents with a diagnosis of dementia out of 21 sampled residents (Residents 74, 80, and 77).</p> <p>Findings include:</p> <p>A review of a facility policy entitled Behavioral Management that was last reviewed on January 16, 2024, indicated that residents exhibiting behaviors that could endanger themselves, other residents, or staff may benefit from a behavioral care plan to ensure that they receive appropriate services and interventions to meet their needs. A behavioral health care plan could include a schedule of daily life events that address the individuality of the resident and should reflect the resident's personal preferences, and usual routines, to the extent possible. The care plan should include the recreational schedule, non-pharmacological interventions, and environmental adjustments needed to help the resident his/her highest practicable well-being. Additionally, the care plan should be reviewed quarterly for continued need of behavioral management and appropriate interventions.</p> <p>A clinical record review revealed that Resident 74 was admitted to the facility on [DATE], with diagnoses that included Alzheimer's disease (a brain disorder that slowly destroys memory and thinking skills and, eventually, the ability to carry out the simplest tasks). A review of a quarterly Minimum Data Set assessment (MDS - a federally mandated standardized assessment process conducted periodically to plan resident care) dated January 16, 2024, revealed that Resident 74 is severely cognitively impaired.</p> <p>Resident 74's care plan dated April 11, 2023, revealed that the resident displayed socially inappropriate behaviors of hitting, punching, and swinging at staff with planned interventions to encourage the resident to interact with others and participate in activities of interest and encouraging the resident to express any feelings, fears, needs, or concerns as able. The resident's care plan, dated October 18, 2022, revealed that the resident had the potential to be verbally and physically aggressive toward staff related to dementia with planned interventions to anticipate the resident's needs, provide physical and verbal cues, and provide the resident with as many choices as possible about care and activities.</p> <p>A progress note dated December 6, 2023, at 5:03 AM indicated that Resident 74 had increased behaviors throughout the night. The resident was observed rummaging in other rooms, wandering with impact on others and himself, hitting and resisting staff attempts at care or redirection. At 10:00 PM on this date Resident 74 was aggressive with care throughout the evening and was observed displaying kicking and hitting behaviors.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395357	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/15/2024
NAME OF PROVIDER OR SUPPLIER Ellen Memorial Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0744</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A progress note dated January 14, 2024, at 8:03 PM indicated that Resident 74 was very angry and agitated during this shift. The resident was wandering around the unit as normal, grabbing other residents' wheelchairs, trays, garbage cans, chairs, and touching other residents. The resident was observed making threatening statements to staff. Close supervision was provided; however, the resident was not receptive to all directions.</p> <p>A record review revealed a Documentation Survey Report dated February 2024, indicating that Resident 74 was observed hitting others on February 1, 2024, and February 4 of 2024; grabbing others on February 1 and 18 of 2024; and wandering on February 3, 4, and 24 of 2024.</p> <p>Nursing progress notes dated February 15, 2024, at 9:06 PM revealed that a nurse aide reported Resident 74 had smacked another resident in the face. The note indicated that the residents were immediately separated, and Resident 74 had no complaints of pain or distress. However, the entry indicated that Resident 74 continued to display increased poor impulse control with behaviors such as wandering into resident rooms and pushing residents in wheelchairs. The note explained that distraction activities were provided and effective for brief periods of time.</p> <p>There was no indication that the facility had implemented an individualized plan of care, including providing purposeful and meaningful activities based on Resident 74's past history, customary routines, and preferences identified, such as gardening, time outdoors, jeopardy, hallmark movies, being read too, crafting, or hymns to address the resident's known dementia related behavior to promote the resident's quality of life and highest practical level of psychosocial well-being and safety.</p> <p>A clinical record review revealed that Resident 80 was admitted to the facility on [DATE], with diagnoses that included dementia. A significant change in status MDS assessment dated [DATE], revealed that Resident 80 is severely cognitively impaired.</p> <p>A review of Resident 80's current care plan revealed that he has a problem with impaired cognitive functions, impaired thought processes, and impulse control related to his diagnosis of dementia, initiated September 3, 2023, with planned interventions to provide cueing, reorienting, and supervising as needed; engaging the resident in simple, structured activities; and providing a program of activities that accommodates the resident's abilities. Resident 80's current care plan revealed that he enjoys 50s and 60s music, word search, reading the newspaper, car magazines, time outdoors, socials, animals, kids, and assisting with bingo.</p> <p>A progress note dated October 18, 2023, at 9:55 PM indicated that Resident 80 was demanding to use the mobility chair of another resident, unbuckling her safety belt, and attempting to lift her from the chair by the arm. Resident 80 was threatening staff and refusing to let go of the other resident's mobility chair for several minutes before redirection was successful. Education was provided to Resident 80 on behaviors. On October 18, 2023, at 10:13 PM Resident 80 was observed displaying increased behaviors this evening. The resident was cursing, degrading, and threatening staff and other residents.</p> <p>A physician's order was noted for Resident 80 to receive Tegretol Oral Tablet (Carbamazepine- an anticonvulsant medication) 100 mg two times a day for impulse control was initiated on October 19, 2023.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395357	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/15/2024
NAME OF PROVIDER OR SUPPLIER Ellen Memorial Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0744</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A progress note dated October 29, 2023, at 11:07 PM indicated that Resident 80 was seeking out a female resident during the shift and required redirection several times. Close monitoring, emotional support, and activities were provided to residents throughout the shift. Progress notes dated October 30, 2023, at 2:55 AM indicated that Resident 80 continued to seek out female residents through the night. The resident was observed following staff in and out of female residents' rooms during care and standing in front of doors. Redirection was effective but only short periods of time.</p> <p>A progress note dated November 6, 2023, at 6:46 AM indicated that Resident 80 was verbally aggressive, cursing, wandering into females' rooms, undressing in hallways, pacing, and unable to settle. The note indicated that snacks, fluids, redirection, toileting, and activities were only effective for short periods of time. On November 15, 2023, at 7:22 PM progress notes indicated that Resident 80 was easily agitated, verbally aggressive, cursing, threatening, and yelling at staff and residents. Redirection, snacks and fluids, puzzle books, and television were not effective. Resident 80 continued to threaten and yell at anyone near him. Resident 80 continued female seeking, cursing, threatening, and throwing objects. On November 24, 2023, Resident 80 was aggressive, restless, and verbally abusive towards staff and other residents. The resident yelled, You bitch, you son's of bitches! Snacks, fluids, toileting, a decrease in stimuli, and emotional support were offered with no change in behavior.</p> <p>A progress note dated December 9, 2023, at 9:54 PM revealed that Resident 80 was verbally combative, yelling, and cursing at staff and other residents. Staff redirected and reapproached the resident with a positive outcome. Snacks were provided to the resident. A progress note dated December 18, 2023, at 2:51 AM revealed that Resident 80 was agitated, short with staff, and in a poor mood. The resident stated, I can't stand this sh*t anymore, let it be. I don't have pain. I just hate people. A progress note dated December 22, 2023, at 5:25 PM indicated that Resident 80 was agitated at the beginning of the shift, accusing, arguing, cursing, pointing, and threatening physical harm to other residents and staff. Progress notes dated December 30, 2023, at 2:54 AM indicated that Resident 80 was awake throughout the night, pacing in the halls, undressing and redressing, being argumentative, cursing at staff and other residents, and knocking on resident bedroom doors. Education, emotional support, redirection, and distraction were provided and were effective for brief periods.</p> <p>A progress note dated January 10, 2024, at 10:28 PM indicated that Resident 80 was wandering into other residents' rooms and was agitated with another male resident. Progress notes dated January 18, 2024, at 10:39 PM indicated Resident 80 had increased restlessness throughout the shift and was attempting to urinate on the floor and undress. The resident required frequent redirection throughout the night. A progress note dated January 26, 2024, at 3:00 AM indicated that Resident 80 had increased restlessness, agitation, yelling, and disrupting others.</p> <p>A clinical record review revealed physician orders dated January 29, 2024, discontinuing Tegretol Oral Tablet (Carbamazepine- an anticonvulsant medication) 100 mg.</p> <p>A progress note dated January 30, 2024, at 3:46 AM revealed that Resident 80 was agitated and restless throughout the night, required four hours of 1:1 supervision due to poor safety awareness. The resident was observed cursing at others, yelling, and grabbing other residents' wheelchairs. The resident's behavior was unchanged with the redirection. Activity was effective for short periods of time.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395357	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/15/2024
NAME OF PROVIDER OR SUPPLIER Ellen Memorial Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0744</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A record review revealed a Documentation Survey Report dated January 2024, indicating that Resident 80 displayed agitation on January 1, 3, 10, 24, 26, 29, and 30 of 2024. The resident was cursing at others, frustration directed at others, or aggression towards others on January 1, 3, 4, 10, and 21 of 2024, and the resident displayed entering other resident rooms on January 3 and 10 of 2024.</p> <p>A progress note dated February 4, 2024, at 11:40 PM indicated that Resident 80 displayed agitation, screaming, cursing at others, and spitting at an aide. The note indicated that the resident was redirected several times, talked and listened too, walked, provided a snack, and toileted. The resident's behavior was unchanged. A progress note dated February 5, 2024, at 9:22 PM indicated that Resident 80 started with increased behaviors at 6:55 PM. Resident 80 cursed at another male resident and threatened others. Redirection, distraction, and anticipation of needs had some effect. Progress note dated February 6, 2024, at 10:40 PM indicated that Resident 80 displayed restlessness, facial flushing, cursing at others, and banging on doors, walls, and banister. Distraction, activity, snacks, and fluids are provided. All effective for brief periods of time. Progress note dated February 10, 2024, at 11:02 PM indicated that Resident 80 attempted to wake up sleeping residents and was physically and verbally aggressive with staff. Ice cream, juice, a puzzle book, and anticipated needs are all effective for brief periods of time.</p> <p>A record review revealed a Documentation Survey Report dated February 2024, indicating that Resident 80 displayed agitation on February 1 and 10 of 2023. The resident displayed cursing at others, frustration directed at others, or physical aggression toward others on February 4, 10, and 12 of 2024.</p> <p>A clinical record review revealed that Resident 80 was in the community hospital from February 28, 2024, through March 8, 2024.</p> <p>There was no indication that the facility had implemented an individualized plan of care, including facilitating purposeful and meaningful activities based on Resident 80's past history, customary routines, and identified activities preferences of music, car magazines, animals, or 50s and 60s music, to address the resident's known dementia-related behavior and promote the resident's quality of life and the highest practical level of psychosocial well-being and safety.</p> <p>During an interview on March 15, 2024, at approximately 10:15 AM, the Nursing Home Administrator and Director of Nursing confirmed the facility had not consistently implemented an effective individualized and person-centered care plan to address Resident 74's or Resident 80's dementia-related behaviors.</p> <p>A review of Resident 77's clinical record revealed that she was admitted to the facility on [DATE], with diagnosis of unspecified dementia, cognitive communication deficit dysphagia, aphagia and anxiety. The resident had severe cognitive impairment according to the clinical record.</p> <p>A quarterly Minimum Data Set assessment (Minimum Data Set - a federally mandated standardized assessment conducted at specific intervals to plan resident care) dated October 13, 2023, revealed that the resident was severely cognitively impaired.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395357	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/15/2024
NAME OF PROVIDER OR SUPPLIER Ellen Memorial Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0744</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The resident's plan of care, initiated January 18, 2022, and last revised on December 19, 2023, with altered behaviors as evidenced by socially inappropriate behaviors such as rummaging through other resident's belongings, disrobing in public, voiding/defecating in inappropriate areas, physically and verbally aggressive, calling anyone near her [NAME]/[NAME] and looking for husband [NAME] and pushing other residents. Resident 77's goal was to not exhibit socially inappropriate behaviors with a goal to encourage the resident to interact with others as able, enjoyed small groups such as sing-a-longs and Rosary. Resident 77's plan of care indicated that the resident was at risk for wandering and had the potential to become physically/verbally aggressive towards staff and others related to dementia.</p> <p>A review of the resident's clinical record nursing progress notes dated October 2023 revealed that Resident 77 had demonstrated repeated escalations in dementia related behaviors on October 4, 2023, October 12, 2023, at 10:10 PM, and October 18, 2023.</p> <p>An incident investigation dated October 18, 2023, at 9:30 p.m., revealed that Resident 77 was observed unbuttoning her shirt and was kissing Resident 80, a severely cognitively impaired male resident on the unit, in the dinette on the Gold Unit. Resident 80's hand was touching Resident 77 in the breast area. Nursing staff witnessed this from down the hall and immediately stopped the interaction. Both residents were separated and provided with increased staff supervision. Both residents attending physicians were notified, and psychiatric services consulted to re-evaluate.</p> <p>On October 19, 2023, at 2:26 a.m., Resident 77 continued to display behaviors during the night shift and was awake and pacing the halls.</p> <p>A Psychiatric Progress Note completed by facility's consultant psychiatric physician dated October 19, 2023, revealed that the resident had increased physical and verbal aggression, was more irritable and impulsive, and was easily agitated and difficult to re-direct. The psych MD assessed and diagnosed the resident with major neurocognitive disorder and increased the resident's dose of Zyprexa (an antipsychotic medication that affects chemicals in the brain and used to treat psychotic conditions such as schizophrenia and bipolar disorder) to 2.5 mg three times daily and to continue to monitor.</p> <p>Further review of Resident 77's clinical record revealed progress note documentation dated from November 2023 through survey ending March 15, 2024, which revealed that the resident continued to have escalating dementia behaviors of verbal and physical aggression towards staff and peers, agitation, wandering/exit seeking behaviors, and rummaging through peer's personal belongings. The resident was disruptive to her peers by following them around and insisting other residents were her spouse.</p> <p>During an observation of the Gold Unit on March 14, 2024, at approximately 10:45 a.m., Resident 77 was observed in another resident's room, room [ROOM NUMBER], laying on the other residents' bed near the door. Continued observation of the Gold Unit revealed that upon exiting the resident activity room, at approximately 11:04 a.m., nursing staff discovered that Resident 77 was not in the correct room and escorted her out. The resident entered the activity room, where a few residents were assembled with the TV on, but did not engage in the activity of watching television and instead began to wander about the unit.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395357	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/15/2024
NAME OF PROVIDER OR SUPPLIER Ellen Memorial Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0744</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The facility failed to demonstrate that it had identified, addressed and/or obtained the necessary services for the dementia care needs of residents including developing individualized interventions related to the resident's symptomology and rate of progression, reviewing and revising care plans that were ineffective, and modifying the residents' environments if needed. The Director of Nursing (DON) when interviewed on March 14, 2023, at 1:05 p.m., confirmed</p> <p>that the interventions developed to prevent intrusive wandering and resident to resident altercations, and related behavioral symptoms, displayed by residents with dementia have not been fully effective.</p> <p>Refer F600 and F679</p> <p>28 Pa. Code 211.12 (d)(3)(5) Nursing services</p> <p>28 Pa. Code 201.18 (e)(1) Management</p> <p>28 Pa. Code 201.29 (a) Resident rights</p>