

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395359	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/21/2025
NAME OF PROVIDER OR SUPPLIER Jersey Shore Skilled Nursing and Rehabilitation Ce		STREET ADDRESS, CITY, STATE, ZIP CODE 1008 Thompson Street Jersey Shore, PA 17740	

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 0604</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment.</p> <p>19719</p> <p>Based on clinical record review, review of select facility policies and procedures, and staff interview, it was determined that the facility failed to ensure that a resident was free from abuse regarding the use of a physical restraint not required to treat a resident's medical symptoms for one of one resident reviewed for restraints resulting in actual harm (Resident 1).</p> <p>Findings include:</p> <p>Review of the policy entitled Abuse Prohibition, last reviewed on September 27, 2024, indicates that the facility prohibits abuse, mistreatment, neglect, misappropriation of resident/patient property, and exploitation for all patients. This includes, but is not limited to, freedom from corporal punishment, involuntary seclusion, and any physical or chemical restraint not required to treat the patient's medical symptoms. Anyone who witnesses an incident of suspected abuse is to report the incident to his or her supervisor immediately.</p> <p>Review of the policy entitled Use of Restraints, last reviewed on September 27, 2024, indicates the patients have the right to be free from any physician or chemical restraints imposed for purpose of discipline or convenience, and not required to treat the patient's medical symptoms. Convenience is defined as the result of any action that has the effect of altering a patient's behavior such that the patient requires a lesser amount of effort or care and is not in the patient's best interest. A physical restraint is defined as any manual method, physical or mechanical device, equipment or material that is attached or adjacent to the body, cannot be easily removed by the patient, and restricts the patient's freedom of movement or normal access to their body. When the use of a restraint is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. There must be documentation identifying the medical symptom being treated and an order for the use of the specific type of restraint. Consent must be obtained prior to the application of the restraint. Emergency restraint use may be used for as a last resort to protect the safety of the patient and others if the patient's unanticipated violent or aggressive behavior places self or others in imminent danger. The order for the restraint must be obtained from the physician either during the application or immediately after the restraint has been applied. Supporting documentation must reflect what the patient was doing and what happened that presented the imminent danger.</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
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<p>F 0604</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of a facility submitted information to the Department of Health dated January 11, 2025, indicated that employees used a sheet across Resident 1's chest and tied her to her chair on January 8, 2025, and again on January 11, 2025.</p> <p>Review of the facility's investigation into Resident 1's use of a sheet as a restraint revealed a statement by Employee 1, licensed practical nurse (LPN), that indicated on January 8, 2025, around 5:00 AM, Resident 1 would not stay in her chair. Employee 1 indicated she put a sheet across her chest and tied it around the chair. There was no evidence in Employee 1's statement nor in Resident 1's clinical record to indicate a medical or emergent need to use a restraint.</p> <p>Review of Employee 2's, LPN, statement dated January 11, 2025, indicated that on January 8, 2025, she observed Resident 1 restrained to a reclining chair with a folded sheet across her chest and abdomen area and tied underneath the back of the chair. Interview with Employee 2 on January 21, 2025, at 1:30 PM confirmed this information. Employee 2 also indicated during the interview that she arrived on the unit around 7:00 AM when she observed this and that she did not report the use of the restraint to her supervisor at that time. Resident 1 was in a restraint for almost two hours.</p> <p>Review of a statement from Employee 3, nurse aide, dated January 11, 2025, indicated that on January 11, 2025, at 6:00 AM she observed Employee 4, LPN, holding Resident 1's arms down while Employee 5, nurse aide, placed a sheet across Resident 1's chest and tied it underneath her chair.</p> <p>Review of Employee 4's statement dated January 11, 2025, indicated that Resident 1 was trying to get up on her own and there was no medication ordered for agitation. Employee 4 stated she notified her supervisor and was told someone had to stay with Resident 1, but we all had work to do.</p> <p>Review of Employee 5's, nurse aide, statement dated January 11, 2025, at 1:15 PM indicated that Resident 1 was trying to hop out of her chair. Employee 5 indicated that she stretched a sheet long like a seat belt over Resident 1's hips and tied it behind the back of her chair. Employee 5's statement indicated that Employee 4 held onto her shoulders. Employee 5 indicated in her statement that other staff had been doing it, even last week. There was no evidence in Employee 5's statement nor in Resident 1's clinical record to indicate a medical or emergent need to use a restraint.</p> <p>Review of a statement from Resident 5, undated, indicated that he saw nursing staff restraining Resident 1's arms. Review of a statement from Resident 6, dated January 14, 2025, indicated that she saw nursing staff tie Resident 1 to her chair, and that Resident 1 was kicking and screaming. Resident 6 also indicated in a separate statement that Resident 1 was screaming and crying as staff were applying the sheet.</p> <p>Review of Resident 1's clinical record revealed no documented evidence to indicate that the facility obtained a physician's order for the use of the restraint, obtained consent before using the restraint, or attempted a least restrictive device. There was no documented evidence in Resident 1's clinical record to indicate that there was an identified medical reason for the use of the restraint, or that an emergency use was appropriate or approved, either on January 8, 2025, or January 11, 2025, when the restraint was used.</p> <p>(continued on next page)</p>		

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<p>F 0604</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Interview with Employee 6, physical therapist, on January 21, 2025, at 9:45 AM revealed that no one in the therapy department had received updated restraint and/or abuse training after Resident 1's incident on January 8, 2025, and January 11, 2025. Review of a list of therapy employees revealed that there are currently nine employees that work with residents.</p> <p>Interview with the Administrator on January 21, 2025, at 1:45 PM acknowledged the above findings, confirmed that the therapy department did not receive additional training until after the surveyors questioning, and confirmed that Employee 2 did not report inappropriate restraint use on January 8, 2025.</p> <p>The facility failed to ensure that a resident was free from abuse regarding using a sheet as a restraint for non-medical and/or non-emergent reasons.</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 211.8 (c.1) Use of Restraints</p> <p>28 Pa. Code 211.12(d)(5) Nursing Services</p>		