STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395359	A. Building B. Wing	04/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Jersey Shore Skilled Nursing and Rehabilitation Ce	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)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on clinical record review, review of facility documents, and resident and staff interview, it was determined that the facility failed to accurately report an incident as an allegation of neglect for one of four residents reviewed (Resident 2). Findings include: Review of a facility reported incident to the State event reporting system dated March 26, 2025, revealed facility staff reported Resident 2 as requiring transfer to the hospital due to an accident /injury on March 26, 2025, at 10:45 AM. The incident indicated that Resident 2 was found lying on the floor in her room with her head on the floor between the bed and nightstand. The resident was reported as having pain to the right knee and right arm, and a hematoma (bruise, a collection of blood that pools outside of a blood vessel) was noted by her right eye. The resident was reported as being sent to the emergency room for evaluation. The incident report was rejected by the State on March 27, 2025, requesting more information regarding if staff followed care plan interventions for Resident 2 at the time the incident occurred. In a final State accepted submission of the incident regarding Resident 2 dated March 31, 2025, facility staff indicated Resident 2's care plan was being followed as the resident has an enabler bar for assisting her to turn and reposition in bed and noted a nurse aide had been in the resident's room within 15 minutes before the incident assisting with morning care. Clinical record review for Resident 2 revealed a late entry note dated March 26, 2025, at 10:45 AM noting the staff member was called to Resident 2's room as the resident was found on the floor by a nurse aide. It was noted the staff member asked the resident what had happened. The resident responded she had rolled out of bed. An additional progress note for Resident 2 dated March 26, 2025, at 10:45 AM noted the staff member was called to Resident 2's room and the resident was lying on the floor on her right side of her abdomen. The writer noted the resident's bed was in the high position when the staff member entered the room. The note also indicated per the nurse aide, morning care was being completed on the resident and the nurse aide left the room for a minute and found the resident on the floor when she returned. (continued on next page)

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

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A progress note dated March 26, 2025, at 11:30 AM revealed one on one education was provided to the nurse aide (NA) on the risks of leaving a resident's bed at the high level and to never walk away from a resident if the bed is at a high level. It was noted the NA voiced understanding. A nurse practitioner note dated March 26, 2025, at 3:07 PM indicated that nursing reported Resident 2 was found on the floor shortly after a nurse aide who was in the process of cleaning her in bed had walked out to get something. It was noted the resident reported she slid out of bed and hit her head on the floor. Further clinical record review for Resident 2 revealed the resident was assessed on February 2, and April 2, 2025, for bed rails and it was determined no rails were to be utilized. There was no evidence Resident 2 was ever ordered an enabler or that they were ever placed on the bed as indicated in the incident report to the State. A review of Resident 2's five-day MDS (minimum data set, an assessment completed at periodic intervals of time to assess resident care needs) dated February 17, 2025, revealed the resident was assessed as being dependent on staff for bathing, hygiene, rolling, and lying to sitting. In an interview and observation of Resident 2 on April 15, 2025, at 1:05 PM, the resident was observed in bed. There were no enabler bars observed on the bed and Resident 2 indicated she never had any. Resident 2 indicated she did have a recent fall from her bed as a nurse aide was bathing her and asked the resident if she would be okay while she went to grab something. While the nurse aide was out of the room, the resident stated she felt her leg slipping off the edge of the bed, and the rest of her just kept going with it and she ended up on the floor. Resident 2 stated she sustained a bruised eye and bruised leg. Review of facility documents, which included witness statements of Resident 2's incident revealed a staff statement that the nurse aide who was providing care to Resident 2 approached the nursing desk to show another staff member a patch from the resident, noting the nurse aide returned to Resident 2's room and them came back to the desk stating the resident rolled out of bed. The statement indicated the nurse aide was asked if the resident was kept on her side and the nurse aide stated yes. The writer indicated when they got to the room Resident 2 was on her face on the floor with the bed as high as it goes. A licensed practical nurse (LPN) witness statement indicated the nurse aide came to the desk to show the nurse Resident 2 needed a new patch, and then returned stating the resident was on the floor. The LPN noted the resident was observed on the floor with the bed in the highest position. The nurse aide providing care to the resident indicated she was washing the resident and the resident's wound bandage was bloody, so the nurse aide rolled the resident on her back to go show the LPN. When the NA came back to the room the resident stated her leg fell off the bed and she rolled with it to the floor. Resident 2's emergency room report from March 26, 2025, indicated the resident sustained a contusion (bruise) of the right knee and scalp. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility failed to accurately report the details of Resident 2's fall sustained on March 26, 2025, as it was indicated the resident had enabler bars, and the care plan was followed. There was no mention of staff leaving the resident as care was being provided, that the resident was left in the highest bed position, or that potential neglect had occurred. The facility obtained statements indicating they completed education with the nurse aide involved due to not following procedure regarding the resident. The facility failed to report a potential allegation of neglect to the appropriate agencies that caused Resident 2 to sustain a fall from bed, and she incurred an emergency room visit with minor injury. The above information was reviewed with the Nursing Home Administrator on April 15, 2025, at 3:26 PM. 28 Pa. Code 201.14(a)(c) Responsibility of licensee. 28 Pa. Code 201.18(b)(1)(e)(1) Management