STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395384	A. Building B. Wing	02/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pocopson Home	1695 Lenape Road West Chester, PA 19382

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 0604 Level of Harm - Actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47968 Based on review of facility policies, resident clinical records, and facility investigative reports, as well as staff interviews, it was determined that the facility failed to ensure residents were free from physical restraints not required to treat the medical symptoms for one of one residents reviewed, resulting in harm to Resident R1 who was physically restrained using a pair of pajama pants tied tightly around resident's waist, causing a reddened area on the resident's skin. Findings include: Review of the facility policy titled, Restraint/Device/Siderail, dated [DATE], revealed it is the policy of Pocopson Homes that all residents are free from physical or chemical restraints imposed for the purposes of discipline or convenience, and not required to treat the resident's medical condition. Restraints will be applied only after a physician's order has been obtained and the family has been notified. Consent must also be signed by the responsible party of the resident. The care plan should be updated, and the appropriate record will be initiated to track the use and release of the restraint. The physician order will include the type of restraint, reason for restraint, how often the restraint is removed. Physical or occupational therapy will be consulted. Further review of the policy revealed that physical restraints include but are not limited to leg/arm restraints, hand mitts, soft ties, vests, [NAME]-walkers, seatbelts which the resident cannot easily open or remove, specialty chairs which resident cannot easily rise from, low beds, bed against the wall, and side rails which prevent the resident from easily getting out of bed. Review of Resident R1's quarterly Minimum Data Set (MDS) assessment (mandated assessment of a resident's abilities and care needs) dated [DATE], revealed the resident was severely cognitively impaired, was not able to make his/her needs known, required extensive assistance for care activities, incontinent of bowel and bladder, and exhibited inattentive behaviors during the assessment period. Review of Resident R1's care plan, dated [DATE], indicated the resident wandered relative to impaired safety awareness. Interventions indicated were to provide structured activities, toileting, walking inside and outside, reorientation strategies including signs and pictures, wander guard bracelet, conversation, and music. (continued on next page)

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0604 Level of Harm - Actual harm Residents Affected - Few	Review of information received by Department of Health regarding Resident R1, received on February 7, 2024, revealed a witness to Resident R1 tied down to a rolling reclining chair. The incident occurred on [DATE]. Review of facility's records failed to reveal an investigation was initiated and Resident R1 was unable to be interviewed due to his/her death on [DATE]. The Director of Nursing initially failed to interview staff involved in Resident R1's care. Review of resident records, facility grievance reports, and electronic reporting system failed to reveal any documentation of incident. Interview with Nursing Home Administrator on February 12, 2024, at 2:00 p.m., revealed the Administrator was not aware of the incident. The Administrator indicated the incident was not reported to the Department of Health, an investigation was not conducted, nor does the facility use any type of restraint. Interview with Director of Nursing on February 12, 2024, at 2:10 p.m., revealed witness statements were provided by staff, but no investigation was initiated of the incident since the resident was known for being restless and attempting to get out of bed and/or chair on his/her own, thus increasing fall risk. Further interview with Director of Nursing revealed the belief that being tied to the scoot chair was not considered a restraint, rather as a method of keeping the resident safe from falls. Review of witness statement from Nurse Assistant (Employee E3) dated [DATE], revealed that non licensed Employee E3 observed Resident R1 tied to a chair at the waist with fleece pajama pants, preventing his/her ability to move or stand up. Review of witness statement from a Registered Nurse, (Employee E4), dated [DATE], revealed that he/she received a call from Employee E3 to come to the floor as it was urgent. Upon arrival on the unit, he/she was asked to observe Resident R1, who was in the bathroom. Licensed Practical Nurse (Employee E5) stated that Resident R1 was found tied to the scoot chair with a pair of fleece pajamas around her trunk/abdominal region. Per Supervisor, Employee E5 stated I immediately removed the pajama pants due to red mark noted. ' Upon assessment, red mark was resolved, and no other injury noted. Review of witness statement from a Licensed Practical Nurse (Employee E5), dated February 12, 2024, revealed when Employee E5 took Resident R1 to the bathroom for incontinence care, Employee E5 was not able to lift Resident R1 out of the scoot chair. Employee E5 found a pair of fleece type pajama pants was tied around the midsection of Resident R1, in a knot, behind the scoot chair. Employee E5 immediately called Employee E3 to witness findings. Employee E5 then called the RN Supervisor, Employee E4 to inform of findings. Employee E5 noticed a reddening area on Resident R1's abdomen, therefore, Employee E5 removed the pajama pants prior to Supervisor Employee E4's arrival on the unit. Review of an undated witness statement from Licensed Practical Nurse (Employee E6), revealed that Employee E6 observed Resident R1 sitting in a scoot chair, Resident R1 was restless, Employee E6 administered PRN (as needed) Morphine around 8:00 p.m., to help with restlessness. Employee E6 denied seeing anything tied around Resident R1 at the time of care. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0604 Level of Harm - Actual harm Residents Affected - Few	Interview conducted with nurse aide, Employee E3 on February 14, 2024, revealed Employee E3 indicated Resident R1 was not therapy approved for scoot chair use, Resident R1 was able to get up on his/her own. When licensed Employee E5 took Resident R1 to the bathroom for continence care Employee E5 noticed the resident was tied to the scoot chair with pajama pants. Employee E5 requested Employee E3 observe his/her findings as a witness. Resident R1was unable to move, due to the material being tightly tied. Further interview with Employee E3, Licensed staff member, Employee E4, requested written statements at the time of the incident. Employee E3 stated to his/her knowledge no further investigation was conducted, and he/she was not questioned further regarding the incident. Review of Resident R1's records revealed a fall risk care plan dated [DATE], documenting Resident R1 was at moderate risk for falls. One of the interventions dated [DATE], noted staff should monitor resident closely after dinner for signs of fatigue such as gait, slower, more unsteady, assist to bed for rest period or chair for rest period if noted. Further review of Resident R1's clinical record revealed a care plan dated [DATE], documenting Resident R1 as a wanderer relative to impaired safety awareness. Intervention, dated [DATE], indicated staff should distract the resident from wandering by offering pleasant diversions, structured activities, food, conversation, television, or books. Resident prefers religious activities and music (jazz, gospel, Motown). Another intervention which was revised [DATE] was for staff to redirect resident to his/her own bed if located in a peer's bed. Encourage rest periods throughout the day, especially in the afternoons. Review of facility records revealed an occupational therapy treatment encounter note dated [DATE], documenting resident was referred for skilled OT evaluation for concave mattress, (bed positioning), and scoot chair (out of bed positioning), and bed rail assessment per [hospice provider]. Scoot chair with resident's name given to resident. Resident transferred to scoot chair with moderate assist of two persons. Resident exhibited optimal posture in the scoot chair. New order for concave mattress placed, per [hospice provider] request. Skilled OT evaluation only since resident is on hospice. Window side bed rail approved to prevent resident from falling out of bed and safety. Review of Resident R1's records failed to reveal a care plan for restlessness, scoot chair use, restraints, or bed rails. Review of Resident R1's records failed to reveal evidence that a pre-restraining assessment and review was completed to determine the need for restraining the resident by tying him/her to a scoot chair. Interview with the Nursing Home Administrator and Director of Nursing on February 14, 2024, at 12:10 p.m. confirmed that no report was made by the facility, no investigation was initiated prior to Department of Health's visit, no pre-restraining assessment was performed, and no restraint documentation was available for Resident R1 since it was the resident was not restrained, rather, staff initiated the restraint to prevent Resident R1 from falling by tying him/her to a scoot chair for safety. 28 Pa. Code 201.18(e)(1) Management 28 Pa. Code 201.29(j) Resident rights 28 Pa. Code 211.8(a) Use of restraint

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(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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38419 Based on clinical record review, facility documentation, and staff interviews it was determined that the facility failed to report allegations of abuse including physical restraint of Resident R1 for one of one residents reviewed. Findings include: Review of the facility policy titled, Restraint/Device/Siderail, dated [DATE], revealed it is the policy of Pocopson Homes that all residents are free from physical or chemical restraints imposed for the purposes of discipline or convenience, and not required to treat the resident's medical condition. Restraints will be applied only after a physician's order has been obtained and the family has been notified. Consent must also be signed by the responsible party of the resident. The care plan should be updated, and the appropriate record will be initiated to track the use and release of the restraint. The physician order will include the type of restraint, reason for restraint, how often the restraint is removed. Physical or occupational therapy will be consulted. Further review of the policy revealed that physical restraints include but are not limited to leg/arm restraints, hand mitts, soft ties, vests, [NAME]-walkers, seatbelts which the resident cannot easily open or remove, specialty chairs which resident cannot easily rise from, low beds, bed against the wall, and side rails which prevent the resident from easily getting out of bed. Review of Resident R1's quarterly Minimum Data Set (MDS) assessment (mandated assessment of a resident's abilities and care needs) dated [DATE], revealed the resident was severely cognitively impaired, was not able to make his/her needs known, required extensive assistance for care activities, incontinent of bowel and bladder, and exhibited inattentive behaviors during the assessment period. Review of Resident R1's care plan, dated [DATE], indicated the resident wandered relative to impaired safety awareness. Interventions indicated were to provide structured activities, toileting, walking inside and outside, reorientation strategies including signs and pictures, wander guard bracelet, conversation, and music. Review of information received by the Department of Health received on February 7, 2024, revealed a witness to Resident R1 tied to a rolling reclining chair. The incident occurred on [DATE]. Review of facility's records failed to reveal an investigation was initiated and Resident R1 was unable to be interviewed due to his/her death on [DATE]. The Director of Nursing initially failed to interview staff involved in Resident R1's care. Review of resident records, facility grievance reports, and facility reported incident system failed to reveal any documentation of incident. Review of documentation provided by Director of Nursing including a witness statement by Nurse Assistant (Employee E3) dated [DATE], revealed, non licensed Employee E3 observed Resident R1 tied to a chair at the waist with fleece pajama pants, preventing his/her ability to move or stand up. (continued on next page)

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(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	Review of witness statement from a Registered Nurse, (Employee E4), dated [DATE], revealed that he/she received a call from Employee E3 to come to the floor as it was urgent. Upon arrival on the unit, he/she was asked to observe Resident R1, who was in the bathroom. Licensed Practical Nurse (Employee E5) stated that Resident R1 was found tied to a scoot chair using a pair of fleece pajamas around her trunk/abdominal region. Per Supervisor, Employee E5 stated I immediately removed the pajama pants due to red mark noted. ' Upon assessment, red mark was resolved, and no other injury noted. Review of witness statement from Licensed Practical Nurse (Employee E5), dated February 12, 2024, revealed when Employee E5 took Resident R1 to the bathroom for incontinence care, Employee E5 was not able to lift Resident R1 out of the scoot chair. Employee E5 found a pair of fleece type pajama pants was tied around the midsection of Resident R1, in a knot, behind the scoot chair. Employee E5 immediately called Employee E3 to witness findings. Employee E5 then called the RN Supervisor, Employee E4 to inform of findings. Employee E5 noticed a reddening area on Resident R1's abdomen, therefore, Employee E5 removed the pajama pants prior to Supervisor Employee E4's arrival on the unit. Review of an undated witness statement from Licensed Practical Nurse (Employee E6), revealed that Employee E6 observed Resident E1 sitting in a scoot chair, Resident R1 was restless, Employee E6 administered PRN (as needed) Morphine around 8:00 p.m., to help with restlessness. Employee E6 denied seeing anything tied around Resident R1 at the time of care. Interview with Nursing Home Administrator on February 12, 2024, at 2:00 p.m., revealed the Administrator was not aware of the incident. The Administrator indicated the incident was not reported to the Department of Health, an investigation was not conducted, nor does the facility use any type of restraint. Interview with Director of Nursing on February 12, 2024, at 2:10 p.m., revealed witness statements were provided by staff, but no investigation was initiated of the incident since the resident was known for being restless and attempting to get out of bed and/or chair on his/her own, thus increasing fall risk. Further interview with Director of Nursing revealed the belief that being tied to the scoot chair was not considered a restraint, rather as a method of keeping the resident safe from falls. Interview conducted with nurse aide, Employee E3 on February 14, 2024, revealed Employee E3 indicated Resident R1 was not therapy approved for scoot chair use, Resident R1 was able to get up on his/her own. When licensed Employee E5 took Resident R1 to the bathroom for continence care Employee E5 noticed the resident was tied to the scoot chair with pajama pants. Employee E5 requested Employee E3 observe his/her findings as a witness. Resident R1was unable to move, due to the material being tightly tied. Further interview with Employee E3, Licensed staff member, Employee E4, requested written statements at the time of the incident. Employee E3 stated to his/her knowledge no further investigation was conducted, and he/she was not questioned further regarding the incident. Review of Resident R1's records revealed a fall risk care plan dated [DATE], documenting Resident R1 was at moderate risk for falls. One of the interventions dated [DATE], noted staff should monitor resident closely after dinner for signs of fatigue such as gait, slower, more unsteady, assist to bed for rest period or chair for rest period if noted. (continued on next page)

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(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	Further review of Resident R1's clinical record revealed a care plan dated [DATE], documenting Resident R1 as a wanderer relative to impaired safety awareness. Intervention, dated [DATE], indicated staff should distract the resident from wandering by offering pleasant diversions, structured activities, food, conversation, television, or books. Resident prefers religious activities and music (jazz, gospel, Motown). Another intervention which was revised [DATE] was for staff to redirect resident to his/her own bed if located in a peer's bed. Encourage rest periods throughout the day, especially in the afternoons. Review of facility records revealed an Occupational Therapy (OT) treatment encounter note dated [DATE], documenting resident was referred for skilled OT evaluation for concave mattress, (bed positioning), and scoot chair (out of bed positioning), and bed rail assessment according to Hospice provider notes. Scoot chair with resident's name given to resident. Resident transferred to scoot chair with moderate assist of two persons. Resident exhibited optimal posture in the scoot chair. New order for concave mattress placed, per [Hospice provider] request. Skilled OT evaluation only since resident is on hospice. Window side bed rail approved to prevent resident from falling out of bed and safety. Review of Resident R1's records failed to reveal a care plan for restlessness, scoot chair use, restraints, or bed rails. Review of Resident R1's records failed to reveal evidence that a pre-restraining assessment and review was completed to determine need for restraint usage with Resident R1. Interview with the Nursing Home Administrator and Director of Nursing on February 14, 2024, at 12:10 p.m. confirmed that no report was made by the facility, no investigation was initiated prior to Department of Health's visit, no pre-restraining assessment was performed, and no restraint documentation was available for Resident R1 since it was the resident was not restrained, rather, staff initiated the restraint to prevent Resident R1 from falling by tying him/her to a scoot chair for safety. 28 Pa. Code 201.18(b)(1)(2) Management 28 Pa. Code 211.12(c)(d)(1)(3)(5) Nursing services

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47968 Based on policy, facility documentation, and clinical record review, it was determined that the facility failed to thoroughly investigate an allegation of physical restraint in a timely manner for one of one resident reviewed (Resident R1). Findings include: Review of the facility policy titled, Restraint/Device/Siderail, dated [DATE], revealed it is the policy of Pocopson Homes that all residents are free from physical or chemical restraints imposed for the purposes of discipline or convenience, and not required to treat the resident's medical condition. Restraints will be applied only after a physician's order has been obtained and the family has been notified. Consent must also be signed by the responsible party of the resident. The care plan should be updated, and the appropriate record will be initiated to track the use and release of the restraint. The physician order will include the type of restraint, reason for restraint, how often the restraint is removed. Physical or occupational therapy will be consulted. Further review of the policy revealed that physical restraints include but are not limited to leg/arm restraints, hand mitts, soft ties, vests, [NAME]-walkers, seatbelts which the resident cannot easily open or remove, specialty chairs which resident cannot easily rise from, low beds, bed against the wall, and side rails which prevent the resident from easily getting out of bed. Review of Resident R1's quarterly Minimum Data Set (MDS) assessment (mandated assessment of a resident's abilities and care needs) dated [DATE], revealed the resident was severely cognitively impaired, was not able to make his/her needs known, required extensive assistance for care activities, incontinent of bowel and bladder, and exhibited inattentive behaviors during the assessment period. Review of Resident R1's care plan, dated [DATE], indicated the resident wandered relative to impaired safety awareness. Interventions indicated were to provide structured activities, toileting, walking inside and outside, reorientation strategies including signs and pictures, wander guard bracelet, conversation, and music. Review of information received by the Department of Health received on February 7, 2024, revealed a witness to Resident R1 tied to a rolling reclining chair. The incident occurred on [DATE]. Review of facility's records failed to reveal an investigation was initiated and Resident R1 was unable to be interviewed due to his/her death on [DATE]. The Director of Nursing initially failed to interview staff involved in Resident R1's care. Review of resident records, facility grievance reports, and facility reported incident system failed to reveal any documentation of incident. Review of documentation provided by Director of Nursing including a witness statement by Nurse Assistant (Employee E3) dated [DATE], revealed, non licensed Employee E3 observed Resident R1 tied to a chair at the waist with fleece pajama pants, preventing his/her ability to move or stand up. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of witness statement from a Registered Nurse, (Employee E4), dated [DATE], revealed that he/she received a call from Employee E3 to come to the floor as it was urgent. Upon arrival on the unit, he/she was asked to observe Resident R1, who was in the bathroom. Licensed Practical Nurse (Employee E5) stated that Resident R1 was found tied to a scoot chair using a pair of fleece pajamas around her trunk/abdominal region. Per Supervisor, Employee E5 stated I immediately removed the pajama pants due to red mark noted. ' Upon assessment, red mark was resolved, and no other injury noted. Review of witness statement from Licensed Practical Nurse (Employee E5), dated February 12, 2024, revealed when Employee E5 took Resident R1 to the bathroom for incontinence care, Employee E5 was not able to lift Resident R1 out of the scoot chair. Employee E5 found a pair of fleece type pajama pants was tied around the midsection of Resident R1, in a knot, behind the scoot chair. Employee E5 immediately called Employee E3 to witness findings. Employee E5 then called the RN Supervisor, Employee E4 to inform of findings. Employee E5 noticed a reddening area on Resident R1's abdomen, therefore, Employee E5 removed the pajama pants prior to Supervisor Employee E4's arrival on the unit. Review of an undated witness statement from Licensed Practical Nurse (Employee E6), revealed that Employee E6 observed Resident E1 sitting in a scoot chair, Resident R1 was restless, Employee E6 administered PRN (as needed) Morphine around 8:00 p.m., to help with restlessness. Employee E6 denied seeing anything tied around Resident R1 at the time of care. Interview with Nursing Home Administrator on February 12, 2024, at 2:00 p.m., revealed the Administrator was not aware of the incident. The Administrator indicate the incident was not reported to the Department of Health, an investigation was not conducted, nor does the facility use any type of restraint. Interview with Director of Nursing on February 12, 2024, at 2:10 p.m., revealed witness statements were provided by staff, but no investigation was initiated of the incident since the resident was known for being restless and attempting to get out of bed and/or chair on his/her own, thus increasing fall risk. Further interview with Director of Nursing revealed the belief that being tied to the scoot chair was not considered a restraint, rather as a method of keeping the resident safe from falls. Interview conducted with nurse aide, Employee E3 on February 14, 2024, revealed Employee E3 indicated Resident R1 was not therapy approved for scoot chair use, Resident R1 was able to get up on his/her own. When licensed Employee E5 took Resident R1 to the bathroom for continence care Employee E5 noticed the resident was tied to the scoot chair with pajama pants. Employee E5 requested Employee E3 observe his/her findings as a witness. Resident R1was unable to move, due to the material being tightly tied. Further interview with Employee E3, Licensed staff member, Employee E4, requested written statements at the time of the incident. Employee E3 stated to his/her knowledge no further investigation was conducted, and he/she was not questioned further regarding the incident. Review of Resident R1's records revealed a fall risk care plan dated [DATE], documenting Resident R1 was at moderate risk for falls. One of the interventions dated [DATE], noted staff should monitor resident closely after dinner for signs of fatigue such as gait, slower, more unsteady, assist to bed for rest period or chair for rest period if noted. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review of Resident R1's clinical record revealed a care plan dated [DATE], documenting Resident R1 as a wanderer relative to impaired safety awareness. Intervention, dated [DATE], indicated staff should distract the resident from wandering by offering pleasant diversions, structured activities, food, conversation, television, or books. Resident prefers religious activities and music (jazz, gospel, Motown). Another intervention which was revised [DATE] was for staff to redirect resident to his/her own bed if located in a peer's bed. Encourage rest periods throughout the day, especially in the afternoons. Review of facility records revealed an Occupational Therapy (OT) treatment encounter note dated [DATE], documenting resident was referred for skilled OT evaluation for concave mattress, (bed positioning), and scoot chair (out of bed positioning), and bed rail assessment according to Hospice provider notes. Scoot chair with resident's name given to resident. Resident transferred to scoot chair with moderate assist of two persons. Resident exhibited optimal posture in the scoot chair. New order for concave mattress placed, per [Hospice provider] request. Skilled OT evaluation only since resident is on hospice. Window side bed rail approved to prevent resident from falling out of bed and safety. Review of Resident R1's records failed to reveal a care plan for restlessness, scoot chair use, restraints, or bed rails. Review of Resident R1's records failed to reveal evidence that a pre-restraining assessment and review was completed to determine need for restraint usage with Resident R1. Interview with the Nursing Home Administrator and Director of Nursing on February 14, 2024, at 12:10 p.m. confirmed that no report was made by the facility, no investigation was initiated prior to Department of Health's visit, no pre-restraining assessment was performed, and no restraint documentation was available for Resident R1 since it was the resident was not restrained, rather, staff initiated the restraint to prevent Resident R1 from falling by tying him/her to a scoot chair for safety. 28 Pa. Code 201.18(b)(1)(2) Management 28 Pa. Code 211.12(c)(d)(1)(3)(5) Nursing services

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 47968 Based on clinical record review and interviews with staff, it was determined that the facility failed to develop a comprehensive care plan related to restlessness, scoot chair use, restraints, or bed rails for Resident R1 which resulted in harm to Resident R1 by being tied to a scoot chair and sustaining reddened area on abdomen. Findings include: Review of Resident R1's quarterly Minimum Data Set (MDS) assessment (mandated assessment of a resident's abilities and care needs) for Resident R1, dated December 19, 2023, revealed the resident was severely cognitively impaired, unable to make his/her needs known, required extensive assistance for care activities, incontinent of bowel/bladder, and exhibited inattentive behaviors during the assessment period. Review of Resident R1's clinical record revealed a progress note date December 26, 2023, at 11:01 pm, noting resident awakened approximately 9:00 pm. Resident continues to try to get up and walk around, Resident has to be redirected several times, but behaviors continue. Review of Resident R1's clinical record revealed progress note dated December 27, 2023, at 1:45 pm, noting received resident sitting in front of common area, very restless and anxious. Received PRN [as needed] 0.5 mg Lorazepam tab at 11:01 pm, prior shift ineffective. Interventions toileting, giving snacks/treats and drinks ineffective. Further review of Resident R1's clinical record revealed a progress note dated December 28, 2023, at 11:41 pm, indicating during the beginning of shift resident was noted to be extremely restless and fidgety. Visibly tired and shows signs and symptoms of pain and discomfort. Noted to not be comfortable. Redirection, toileting, snack, and fluids provided with unsuccessful outcomes. Additional review of Resident R1's clinical record revealed a late entry behavior note for 11pm-7 am shift of December 27, 2023, into December 28, 2023, dated December 28, 2023, at 11:41, indicating resident was awake and extremely restless throughout the shift. Redirection and interventions were all ineffective. Review of Resident R1's clinical record revealed progress noted dated December 29, 2023, at 9:53 pm, noted resident awaken around 9:00 pm, and got out of bed and began walking around room. Roommate rang call light to alert staff and resident removed from the bedroom and placed in wheelchair. Resident toileted and placed back into wheelchair. Continued to be restless and grabbing at anyone and anything. Given PRN [as needed] Morphine which had little success. Continued review of Resident R1's clinical record revealed a progress note dated December 30, 2023, at 2:27 pm, indicating the resident woken up for lunch and was observed by this nurse trying to get out of bed, leaning over bed as if to fall. This nurse assisted resident to wheelchair. Fed lunch by this nurse, consumed 100%, During lunch resident restless/anxious unable to sit still or be redirected. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395384	A. Building B. Wing	02/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pocopson Home	1695 Lenape Road West Chester, PA 19382

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F 0656 Level of Harm - Actual harm Residents Affected - Few	Review of Resident R1's records revealed a fall risk care plan dated December 27, 2021, indicating Resident R1 was at moderate risk for falls. One of the interventions, dated October 10, 2023, indicated staff should monitor resident closely after dinner for signs of fatigue such as gait, slower, more unsteady, assist to bed for rest period or chair for rest period if noted. Further review of Resident R1's records revealed a care plan dated December 27, 2021, documenting Resident R1 as a wanderer relative to impaired safety awareness. One of the interventions dated December 27, 2021, noted staff should distract the resident from wandering by offering pleasant diversions, structured activities, food, conversation, television, or books. Resident prefers religious activities and music (jazz, gospel, Motown). One revised intervention dated June 28,2023 was observed noting staff should redirect resident to his/her own bed if located in a peer's bed. Encourage rest periods throughout the day, especially in the afternoons. Review facility documentation including a witness statement from Nurse Assistant (Employee E3) dated December 29, 2023, revealed non licensed Employee E3 observed Resident R1 tied to a chair at the waist with fleece pajama pants, preventing his/her ability to move or stand up. Review of facility documentation including a witness statement from a Registered Nurse, (Employee E4), dated December 30, 2023, revealed that he/she received a call from Employee E3 to come to the floor as it was urgent. Upon arrival on the unit, he/she was asked to observe Resident R1, who was in the bathroom. Licensed Practical Nurse (Employee E5) stated that Resident R1 was found tied to the scoot chair with a pair of fleece pajamas around her trunk/abdominal region. Per Supervisor, Employee E5 stated I immediately removed the pajama pants due to red mark noted.' Upon assessment, red mark was resolved, and no other injury noted. Review of facility records revealed an occupational therapy treatment encounter note dated January 4, 2024, documenting resident was referred for skilled OT evaluation for concave mattress, (bed positioning), and scoot chair (out of bed positioning), and bed rail assessment per [Hospice provider]. Scoot chair with resident's name given to resident. Resident transferred to scoot chair with moderate assist of two persons. Resident exhibited optimal posture in the scoot chair. New order for concave mattress placed, per [Hospice provider] request. Skilled OT evaluation only since resident is on hospice. Window side bed rail approved to prevent resident from falling out of bed and safety. Review of witness statement from a Licensed Practical Nurse (Employee E5), dated February 12, 2024, revealed when Employee E5 took Resident R1 to the bathroom for incontinence care, Employee E5 was not able to lift Resident R1 out of the scoot chair. Employee E5 found a pair of fleece type pajama pants was tied around the midsection of Resident R1, in a knot, behind the scoot chair. Employee E5 immediately called Employee E3 to witness findings. Employee E5 then called the RN Supervisor, Employee E4 to inform of findings. Employee E5 noticed a reddening area on Resident R1's abdomen, therefore, Employee E5 removed the pajama pants prior to Supervisor Employee E4's arrival on the unit. Review of an undated witness statement from Licensed Practical Nurse (Employee E6), revealed that Employee E6 observed Resident R1 sitting in a scoot chair, Resident R1 was restless, Employee E6 administered PRN (as needed) Morphine around 8:00 p.m., to help with restlessness. Employee E6 denied seeing anything tied around Resident R1 at the time of care. Review of Resident R1's records failed to reveal a care plan for restlessness, scoot chair use, restraints, or bed rails. (continued on next page)

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F 0656 Level of Harm - Actual harm Residents Affected - Few	Interview with the Nursing Home Administrator and Director of Nursing on February 14, 2024, at 12:10 p.m. confirmed that no pre-restraining assessment was performed, and no restraint documentation, including a care plan, was available for Resident R1 since it was the administrations opinion that Resident R1 was not restrained, rather, staff were taking it upon themselves to prevent Resident R1 from falling by tying him/her to a scoot chair for safety. It was confirmed that Resident R1 was approved for window side bedrail and scoot chair yet review of resident records failed to reveal a care plan for either. It was confirmed that Resident R1 showed signs of terminal restlessness yet review of resident records failed to reveal a care plan with interventions for this condition. 28 Pa Code 211.12(d)(5) Nursing services