STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395387	A. Building B. Wing	12/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fulton County Medical Center	214 Peach Orchard Road McConnellsburg, PA 17233

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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 48809 Based on a review of facility policies, investigative reports, clinical records, and staff education records, as well as staff interviews, it was determined that the facility failed to ensure that residents were free from neglect for one of two residents reviewed (Resident 1), resulting in a dislocated shoulder. Findings include: The facility's policy regarding abuse and neglect, dated March 14, 2024, indicated that every resident has the right to be free from verbal, sexual, physical, and mental abuse; corporal punishment; and involuntary seclusion. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 1, dated September 17, 2024, revealed that the resident was cognitively impaired and was dependent on staff for all daily care needs. A nursing note for Resident 1, dated November 17, 2024, at 12:11 p.m., revealed that Resident 1 was exhibiting increased behaviors and requested something for pain. A nursing note for Resident 1, dated November 18, 2024, at 3:30 p.m., revealed that she had multiple scattered bruises on her upper arm measuring 15.0 centimeters (cm) x 8.5 cm and the arm was painful with touch. A nursing note for Resident 1, dated November 19, 2024, at 11:28 a.m., revealed that the bruise on the resident's upper arm was larger and the arm was more swollen. The resident was complaining of increased pain. New orders were received for an x-ray of the left upper arm. The x-ray report for Resident 1, dated November 19, 2024, at 12:22 p.m., revealed a dislocated left shoulder. (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 0600 Level of Harm - Actual harm Residents Affected - Few	Review of the facility's investigation for Resident 1, dated November 19, 2024, revealed that on November 14, 2024, Resident 1 was yelling and resisting care. A witness statement by Nurse Aide 1, dated November 20, 2024, revealed that she observed Nurse Aide 2 force Resident 1's left arm above her head, back against the bed, and then force the arm back to a normal position while putting on her deodorant. Nurse Aide 1 stated that she immediately observed a deformity in Resident 1's left shoulder and that the resident was complaining of pain, as well as tingling in her fingers. The investigation by the facility determined that Nurse Aide 2's forceful movement of Resident 1's arm caused the dislocated shoulder. An interview with Registered Nurse 3 on December 3, 2024, at 11:20 a.m. revealed that she assessed Resident 1 on November 15, 2024, when the resident was complaining of pain; however, she did not assess the resident's upper arm or shoulder. She stated that she only assessed from the elbow down because the resident was being resistive with the assessment. She medicated the resident for pain. An interview with the Director of Nursing on December 3, 2024, at 11:55 a.m. confirmed that Nurse Aide 2 forcibly raised and lowered Resident 1's left arm resulting in a dislocated shoulder. 28 Pa. Code 201.14(a) Responsibility of Licensee. 28 Pa. Code 201.18(b)(1)(e)(1) Management. 28 Pa. Code 201.29(j) Resident Rights.

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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 0607 Level of Harm - Actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 48809 Based on review of policies, investigative reports, and clinical records, as well as staff interviews, it was determined that the facility failed to ensure that allegations of possible abuse were reported timely to the Nursing Home Administrator for one of two residents reviewed (Resident 1) resulting in pain and a delay in treatment for a dislocated shoulder. Findings include: The facility's abuse policy, dated March 14, 2024, indicated that staff were to report any allegation or suspicion of abuse immediately to their supervisor, and if the perpetrator was an employee, he/she would be suspended pending investigation to ensure protection of the resident. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 1, dated September 17, 2024, revealed that the resident was cognitively impaired and was dependent on staff for all daily care needs. A nursing note for Resident 1, dated November 17, 2024, at 12:11 p.m., revealed that Resident 1 was exhibiting increased behaviors and requested something for pain. A nursing note for Resident 1, dated November 18, 2024, at 3:30 p.m., revealed that she had multiple scattered bruises on her upper arm measuring 15.0 centimeters (cm) x 8.5 cm and the arm was painful with touch. A nursing note for Resident 1, dated November 19, 2024, at 11:28 a.m., revealed that the bruise on the resident's upper arm was larger and the arm was more swollen. The resident was complaining of increased pain. New orders were received for an x-ray of the left upper arm. The x-ray report for Resident 1, dated November 19, 2024, at 12:22 p.m., revealed a dislocated left shoulder. Review of the facility's investigation for Resident 1, dated November 19, 2024, revealed that on November 14, 2024, Resident 1 was yelling and resisting care. A witness statement by Nurse Aide 1, dated November 20, 2024, revealed that she observed Nurse Aide 2 force Resident 1's left arm above her head, back against the bed, and then force the arm back to a normal position while putting on her deodorant. Nurse Aide 1 stated that she immediately observed a deformity in Resident 1's left shoulder and that the resident was complaining of pain, as well as tingling in her fingers. The investigation by the facility determined that Nurse Aide 2's forceful movement of Resident 1's arm caused the dislocated shoulder. An interview with Registered Nurse 3 on December 3, 2024, at 11:20 a.m. revealed that she assessed Resident 1 on November 15, 2024, when the resident was complaining of pain; however, she did not assess the resident's upper arm or shoulder. She stated that she only assessed from the elbow down because the resident was being resistive with the assessment. She medicated the resident for pain. (continued on next page)

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F 0607 Level of Harm - Actual harm Residents Affected - Few	There was no documented evidence that the alleged abuse witnessed by Nurse Aide 1 on November 14, 2024, was reported to anyone until she was questioned on November 20, 2024. Interview with the Director of Nursing on December 3, 2024, at 11:55 a.m. revealed that Nurse Aide 1 failed to report the allegations of abuse timely causing a delay in care and treatment for Resident 1 who suffered a dislocated shoulder. 28 Pa. Code 201.18(e)(1) Management.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 48809 Based on review of clinical records and investigative reports, as well as staff interviews, it was determined that the facility failed to ensure that residents' clinical records were complete and accurately documented for one of four residents reviewed (Resident 1). Findings include: A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 1, dated September 17, 2024, revealed that the resident was cognitively impaired and was dependent on staff for all daily care needs. Review of the facility's investigation for Resident 1, dated November 19, 2024, revealed that on November 14, 2024, Resident 1 was yelling and resisting care. A witness statement by Nurse Aide 1, dated November 20, 2024, revealed that she observed Nurse Aide 2 force Resident 1's left arm above her head, back against the bed, and then force the arm back to a normal position while putting on her deodorant. Nurse Aide 1 stated that she immediately observed a deformity in Resident 1's left shoulder and that the resident was complaining of pain, as well as tingling in her fingers. The resident was assessed for pain by Registered Nurse 4 and medicated for pain. An interview with Registered Nurse 3 on December 3, 2024, at 11:20 a.m. revealed that she assessed the resident on November 15, 2024, when the resident was complaining of pain; however, she did not assess the upper arm or shoulder. She stated she only assessed from the elbow down because the resident was being resistant towards the assessment. She medicated the resident for pain. There was no documented evidence in Resident 1's clinical record to indicate that she was assessed by the registered nurse on November 14 or November 15, 2024. Interview with the Director of Nursing on December 3, 2024, at 11:55 a.m. confirmed that there was no documented evidence in Resident 1's clinical record to indicate that she was assessed by a registered nurse on November 14 or 15, 2024, and there should have been. 28 Pa. Code 211.5(f) Clinical Records. 28 Pa. Code 211.12(d)(5) Nursing Services.