STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395430	A. Building B. Wing	04/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dubois Nursing Home	212 S. Eighth St. Dubois, PA 15801

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 0656 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 47819 Based on a review of clinical records and investigation documents as well as staff interviews, it was determined that the facility failed to implement a care plan for one of five residents reviewed (Resident 2) who was an assist of two for transfers, resulting in a fall with fracture. This deficiency is being cited as past noncompliance. Findings include: An annual Minimum Data Set (MDS) assessments (required assessments of a resident's abilities and care needs) for Resident 2, dated March 1, 2024, indicated that the resident was cognitively impaired, required assistance from staff for daily care needs including transfers, and had diagnoses that included dementia and high blood pressure. A care plan, dated November 15, 2023, revealed that the resident was to be transferred by two staff and a front-wheeled walker. An incident report for Resident 2, dated March 27, 2024, at 4:30 p.m., indicated that the resident was yelling to go to the bathroom. Nurse Aide 1 went in to assist the resident and asked Licensed Practical Nurse 2 (who was in the hallway doing her medication pass) how the resident transferred and was told she was an assist of one. Nurse Aide 1 proceeded to assist the resident to the bathroom and transferred her to the toilet. During the transfer from the toilet to her wheelchair, Resident 2 lost her balance and fell . Nurse Aide 1 stated that she tried to steady her but was unable to. A nursing note for Resident 2, dated March 27, 2024, at 4:30 p.m., indicated that the resident had a fall in the bathroom. She had complaints of left lower extremity pain. The resident had a left lower extremity deformity and a lump to her left forehead. The physician was notified and ordered the resident to be transferred to the local emergency room . A nursing note for Resident 2, dated March 28, 2024, at 12:42 a.m., revealed that she had a left tibia and fibula (the two bones from the knee to the ankle) fracture that is non-operable and the resident will be returning to the nursing home. (continued on next page)

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395430	A. Building B. Wing	04/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dubois Nursing Home	212 S. Eighth St. Dubois, PA 15801

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 0656 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	A witness statement completed by Nurse Aide 1, dated March 28, 2024, indicated that Resident 2 was yelling that she had to go to the bathroom and her call bell was ringing. She asked Licensed Practical Nurse 2 how the resident transferred because she did not know the resident and was not assigned to her. She asked if she was an assist of one and Licensed Practical Nurse 2 said yes. She stated that she got slipper socks from the resident's drawer and put them on the resident. She transferred the resident into her wheelchair and transferred her to the bathroom. The resident stood and got on the toilet with no issues transferring. She stated that she stayed with Resident 2 until she was finished using the bathroom then stood the resident up with the wheeled walker and cleaned her up. The resident stated she needed to sit down, so Nurse Aide 1 sat her down and rang the call bell for assistance and waited awhile and no one came to assist her. She stated that she checked the hallway and went to the nurse's station for assistance. The resident began yelling that she wanted off the toilet. As she assisted the resident off the toilet her legs began to buckle and the resident fell , and she was unable to stop her. She stated the resident hit her head. She went to get the licensed practical nurse and registered nurse. She was then informed that the resident was to be a transfer assist of two staff members. She stated that she did not have access to the resident's care plan on the iPad and she did not know how to find the transfer status in the charting. A witness statement completed by Licensed Practical Nurse 2, dated March 28, 2024, revealed that she heard the resident yelling out to go to the bathroom and Nurse Aide 1 asked her if she goes to the bathroom. Licensed Practical Nurse 2 indicated that she does use the bathroom because she has helped with toileting her in the past. She then heard Nurse Aide 1 yell that the resident fell . She went with the registered nurse to assist the resident. Licensed Practical Nurse 2 denied telling Nurse Aide 1 that the resident was a one assist for transfers. Interview with the Nursing Home Administrator on April 10, 2024, at 1:29 p.m. confirmed that the resident was to be an assist of two staff members and that the transfer status was not followed per Resident 2's care plan. A review of the facility's plan of correction included the following: Reeducation and competencies for transfer status and verifying transfer status in the charting system were completed for all nursing staff, including agency nursing staff. Audits of all agency staff were completed to verify their access to the facility's charting system. A process was added to the orientation program to verify the staff member has access to the facility's charting system. Audits have been conducted on accessing resident transfer status in the charting system. Interviews with nursing staff on April 10, 2024, revealed that they had been educated and were aware of how to locate a resident's transfer status in the charting system. A review of the facility's corrective actions revealed that they were in compliance with F656 on April 2, 2024. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395430	A. Building B. Wing	04/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dubois Nursing Home	212 S. Eighth St. Dubois, PA 15801

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 0656 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Interview with the Nursing Home Administrator on April 10, 2024, at 1:29 p.m. revealed that staff education was completed, and ongoing audits will be discussed during the monthly Quality Assurance meeting. 28 Pa. Code 201.24(e)(4) Admission Policy. 28 Pa. Code 211.12(d)(5) Nursing Services.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395430	A. Building B. Wing	04/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dubois Nursing Home	212 S. Eighth St. Dubois, PA 15801

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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 28177 Based on review of investigation documents and residents' clinical records, as well as staff interviews, it was determined that the facility failed to maintain a safe environment for one of five residents reviewed (Resident 2), resulting in a fall with fracture. This deficiency was cited as past non-compliance. Findings include: An annual Minimum Data Set (MDS) assessments (required assessments of a resident's abilities and care needs) for Resident 2, dated March 1, 2024, indicated that the resident was cognitively impaired, required assistance from staff for daily care needs including transfers, and had diagnoses that included dementia and high blood pressure. A care plan, dated November 15, 2023, revealed that the resident was to be transferred by two staff and a front-wheeled walker. A nursing note for Resident 2, dated March 27, 2024, at 4:30 p.m., indicated that the resident had a fall in the bathroom. She had complaints of left lower extremity pain. The resident had a left lower extremity deformity and a lump to her left forehead. The physician was notified and ordered the resident to be transferred to the local emergency room . A nursing note for Resident 2, dated March 28, 2024, at 12:42 a.m., revealed that she had a left tibia and fibula (the two bones from the knee to the ankle) fracture that is non-operable and the resident will be returning to the nursing home. An incident report for Resident 2, dated March 27, 2024, at 4:30 p.m., indicated that the resident was yelling to go to the bathroom. Nurse Aide 1 went in to assist the resident and asked Licensed Practical Nurse 2 (who was in the hallway doing her medication pass) how the resident transferred and was told she was an assist of one. Nurse Aide 1 proceeded to assist the resident to the bathroom and transferred her to the toilet. During the transfer from the toilet to her wheelchair, Resident 2 lost her balance and fell . Nurse Aide 1 stated that she tried to steady her but was unable to. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395430	A. Building B. Wing	04/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dubois Nursing Home	212 S. Eighth St. Dubois, PA 15801

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 0689 Level of Harm - Actual harm Residents Affected - Few	A witness statement completed by Nurse Aide 1, dated March 28, 2024, indicated that Resident 2 was yelling that she had to go to the bathroom and her call bell was ringing. She asked Licensed Practical Nurse 2 how the resident transferred because she did not know the resident and was not assigned to her. She asked if she was an assist of one and Licensed Practical Nurse 2 said yes. She stated that she got slipper socks from the resident's drawer and put them on the resident. She transferred the resident into her wheelchair and transferred her to the bathroom. The resident stood and got on the toilet with no issues transferring. She stated that she stayed with Resident 2 until she was finished using the bathroom then stood the resident up with wheeled walker and cleaned her up. The resident stated she needed to sit down so Nurse Aide 2 sat her down and rang the call bell for assistance and waited awhile and no one came to assist her. She stated that she checked the hallway and went to the nurse's station for assistance. The resident began yelling that she wanted off the toilet. As she assisted the resident off the toilet her legs began to buckle and the resident fell , and she was unable to stop her. She stated the resident hit her head. She went to get the licensed practical nurse and registered nurse. She was then informed that the resident was to be a transfer assist of two staff members. She stated that she did not have access to the resident's care plan on the iPad and she did not know how to find the transfer status in the charting. A witness statement completed by Licensed Practical Nurse 2, dated March 28, 2024, revealed that she heard the resident yelling out to go to the bathroom and Nurse Aide 1 asked her if she goes to the bathroom. Licensed Practical Nurse 2 indicated that she does use the bathroom because she has helped with toileting her in the past. She then heard Nurse Aide 1 yell that the resident fell . She went with the registered nurse to assist the resident. Licensed Practical Nurse 2 denies telling Nurse Aide 1 that the resident was a one assist for transfers. Interview with the Nursing Home Administrator on April 10, 2024, at 1:29 p.m. confirmed that the resident was to be an assist of two staff members and that the transfer status was not followed per Resident 2's care plan. A review of the facility's plan of correction included the following: Reeducation and competencies for transfer status and verifying transfer status in the charting system were completed for all nursing staff, including agency nursing staff. Audits of all agency staff were completed to verify their access to the facility's charting system. A process was added to the orientation program to verify the staff member has access to the facility's charting system. Audits have been conducted on accessing resident transfer status in the charting system. Interviews with nursing staff on April 10, 2024, revealed that they had been educated and were aware of how to locate a resident's transfer status in the charting system. A review of the facility's corrective actions revealed that they were in compliance with F689 on April 2, 2024. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395430	A. Building B. Wing	04/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dubois Nursing Home	212 S. Eighth St. Dubois, PA 15801

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 0689 Level of Harm - Actual harm Residents Affected - Few	Interview with the Nursing Home Administrator on April 10, 2024, at 1:29 p.m. revealed that staff education was completed, and ongoing audits will be discussed during the monthly Quality Assurance (QA) meeting. 28 Pa. Code 211.12(d)(1)(5) Nursing Services.