

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395430	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/03/2026
NAME OF PROVIDER OR SUPPLIER Dubois Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>Based on review of facility policy and clinical records, as well as observations and staff interviews, it was determined that the facility failed to provide appropriate respiratory care for one of seven residents reviewed (Resident 5). Findings include: Review of facility policy for oxygen administration by nasal cannula or mask dated February 27, 2026, indicated that residents who require oxygen will have a physician's order which includes the oxygen flow rate. An annual Minimum Data Set (MDS) assessment (a federally mandated assessment of the resident's abilities and care needs) for Resident 5 dated January 22, 2026, indicated that the resident had moderate cognitive impairment, required assistance from staff for daily care needs, had diagnoses that included heart failure, and was receiving supplemental oxygen. Physician's orders for Resident 5 dated February 13, 2024, indicated that the resident was to receive oxygen at three Liters per minute (L/min) via nasal cannula (a lightweight, flexible tube with two small prongs that sits in the nostrils to deliver supplemental oxygen). Observation of Resident 5 on March 3, 2026, at 11:25 a.m. revealed the resident sitting in her wheelchair in her room, with a nasal cannula in place attached to a portable oxygen tank that was empty. Interview with Licensed Practical Nurse 1 on March 3, 2026, at 11:25 a.m. confirmed that Resident 5's portable oxygen tank was empty, and she replaced it with a full one. Observation of Resident 5 on March 3, 2026, at 12:04 p.m. revealed the resident sitting in her wheelchair in the dining room with a nasal cannula in place attached to a portable oxygen tank that had the oxygen flow rate set at 2 L/min. Interview with Licensed Practical Nurse 2 on March 3, 2026, at 12:04 p.m. confirmed that Resident 5's oxygen flow rate was set at 2 L/min and the physician's orders indicated that it should be set at 3 L/min. Interview with the Director of Nursing on March 3, 2026, at 12:56 p.m. confirmed that oxygen should have been administered to Resident 5 according to her physician's orders. 28 Pa. Code 211.12(d)(1)(5) Nursing services</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 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>Based on review of established infection control guidelines, facility policy, and residents' clinical records, as well as observations and staff interviews, it was determined that the facility failed to follow infection control guidelines from the Centers for Medicare/Medicaid Services (CMS) and the Centers for Disease Control (CDC) to reduce the spread of infections and prevent cross-contamination for one of seven residents reviewed (Resident 7). Findings include: CDC guidance on isolation precautions and Implementation of Personal Protective Equipment (PPE) use in Nursing Homes to Prevent Spread of Multidrug-Resistant Organisms (MDRO's - bacteria that have become resistant to certain antibiotics, and these antibiotics can no longer be used to control or kill the bacteria), dated July 12, 2022, indicates that MDRO transmission is common in skilled nursing facilities, contributing to substantial resident morbidity and mortality and increased healthcare costs. Enhanced Barrier Precautions (EBP) are an infection control intervention designed to reduce transmission of resistant organisms that employs targeted gown and glove use during high contact resident care activities. CMS updated its infection prevention and control guidance effective April 1, 2024. The recommendations now include the use of EBP during high-contact care activities for residents with chronic wounds or indwelling medical devices, regardless of their MDRO status, in addition to residents who have an infection or colonization with a CDC-targeted or other epidemiologically important MDRO when contact precautions do not apply. The facility policy for transmission-based precautions dated February 27, 2026, indicated that transmission-based precautions are initiated when a resident develops signs and symptoms of a transmissible infection; arrives for admission with symptoms of an infection; or has a laboratory confirmed infection; and is at risk of transmitting the infection to other residents. Contact precautions staff will wear gloves and disposable gown upon entering the room and remove them before leaving the room. An admission Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 7, dated February 24, 2026, revealed that the resident was cognitively intact, required assistance for daily care needs, and medical diagnosis that includes urinary tract infection. A physician order for Resident 7, dated February 21, 2026, included an order for the resident to be on contact isolation for diagnosis of MDRO. Observations on March 3, 2026, at 11:01 a.m. revealed that Nurse Aide 3 was assisting Resident 7 into the bathroom. She did not have a gown per contact isolation policy. Interview with Nurse Aide 3 on March 3, 2026, at 11:01 a.m. confirmed that she did not have an isolation gown on while providing care to Resident 7 and should have. Interview with Licensed Practical Nurse 4 on March 3, 2026, at 11:10 a.m. confirmed that Resident 7 had orders for contact isolation for MDRO. Interview with the Director of Nursing on March 3, 2026, at 12:57 p.m. confirmed that Nurse Aide 3 should have had a gown on when providing care to Resident 7. 28 Pa. Code 201.14(a) Responsibility of Licensee. 28 Pa. Code 201.18(e)(1) Management. 28 Pa. Code 211.12(d)(1)(5) Nursing Services.</p>		