

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 05/15/2025
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 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>38012</p> <p>Based on clinical record reviews, as well as resident and staff interviews, it was determined that the facility failed to develop an individualized care plan for three of 49 residents reviewed (Residents 26, 48, 110).</p> <p>Findings include:</p> <p>A comprehensive Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 26, dated March 24, 2025, indicated that the resident was alert and oriented, had diagnoses that included diabetes, and was on a mechanically altered, therapeutic diet.</p> <p>Resident 26's care plan, dated March 24, 2025, revealed that it did not include any information or interventions related to the resident's nutritional needs.</p> <p>An interview with Resident 26 on May 12, 2025, at 9:31 a.m. revealed that she was not happy with the food choices she received and that she was not offered a snack at night, even though she was a diabetic.</p> <p>An interview with the Dietician on May 15, 2025, at 8:30 a.m. confirmed that Resident 26's care plan did not include anything regarding the resident's nutritional status and that it should have.</p> <p>A comprehensive MDS assessment for Resident 48, dated April 6, 2025, indicated that the resident was alert and oriented and was frequently incontinent of urine and bowel. According to the resident's task record, dated April 2025, the resident was incontinent of urine 41 times in the month and incontinent of bowel 11 times in the month.</p> <p>Resident 48's care plan, dated April 6, 2025, did not include any information or interventions related to the resident's incontinence.</p> <p>An interview with the Nursing Home Administrator on May 15, 2025, at 8:30 a.m. confirmed that Resident 48's care plan did not include anything regarding the resident's incontinence and that it should have.</p> <p>(continued on next page)</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 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A comprehensive MDS assessment for Resident 110, dated April 15, 2025, indicated that the resident was alert and oriented. A nurse's note, dated April 23, 2025, revealed that the resident's daughter could not tolerate orange juice because of a hiatal hernia (protrusion of an organ, usually the stomach, through the esophageal opening in the diaphragm). A nursing note, dated May 8, 2025, revealed that the resident's daughter requested Tums for the resident and that she not have tomato soup because of her hiatal hernia and the acid causing heartburn. She asked that dietary not send her tomatoes in the future.</p> <p>Resident 110's care plan, dated April 23, 2025, revealed that it did not include any information or interventions related to the resident's hiatal hernia.</p> <p>An interview with the Director of Nursing on May 15, 2025, at 11:21 a.m. confirmed that Resident 110's care plan did not include anything regarding the resident's hiatal hernia and that it should have.</p> <p>28 Pa. Code 201.24(e)(4) Admission Policy.</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>48941</p> <p>Based on clinical record review, as well as staff interviews, it was determined that the facility failed to ensure care and services were provided in accordance with professional standards for two of 49 residents reviewed (Residents 62, 126).</p> <p>Findings include:</p> <p>The Pennsylvania Code, Title 49, Professional and Vocational Standards, State Board of Nursing, 21.11 (a)(1)(2)(4) indicated that the registered nurse was to collect complete and ongoing data to determine nursing care needs, analyze the health status of individuals and compare the data with the norm when determining nursing care needs, and carry out nursing care actions that promote, maintain and restore the well-being of individuals.</p> <p>A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 62, dated March 11, 2025, revealed that the resident was cognitively intact, required assistance for care needs, was taking an antipsychotic medication (medications used to treat mental health disorders), and had diagnoses that included dementia.</p> <p>A nursing note for Resident 62, dated April 30, 2025, at 8:51 p.m., indicated that there was an order to gradually decrease the resident's Abilify (an antipsychotic medication) from 5 milligrams (mg) to 2.5 mg at bedtime per vital health care recommendations.</p> <p>Physician's orders for Resident 62, dated April 30, 2025, included orders for the resident to receive 2.5 mg of Abilify via her peg tube (a mechanical device surgically implanted into the stomach to provide nutrition, fluids and medications to a person who is unable to eat or drink by mouth) at bedtime.</p> <p>Review of Resident 62's Medication Administration Record (MAR) for May 2025 revealed that the resident received 2.5 mg and 5 mg of Abilify at bedtime on May 1, 2025, for a total of 7.5 mg.</p> <p>Interview with the Director of Nursing on May 14, 2025, at 1:57 p.m. confirmed that Resident 62 did receive both the 5 mg tablet and the 2.5 mg tablet of Abilify on May 1, 2025, for a total of 7.5 mg. She confirmed that the new dose was ordered, but the old dose was not discontinued, resulting in an extra dose.</p> <p>An admission (MDS) for Resident 126, dated May 5, 2025, revealed that the resident was moderately cognitively impaired, required assistance for care needs, had an indwelling urinary catheter, and a right upper arm PICC (peripherally inserted central line catheter, a flexible tube placed in the arm for intravenous medications), and had diagnoses that included, right hip fracture and obstructive uropathy (decreased urine flow).</p> <p>Nursing notes for Resident 126, dated April 29, 2025, indicted that the resident was admitted to the facility post hospitalization for a left hip fracture sustained after a syncopal (dizzy) episode and fall on on April 20, 2025.</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Discharge notes from the hospital, dated April 29, 2025, indicated that the resident was discharged with a urinary catheter and a PICC line in place. Notes further indicated that the catheter remained in place after discharge because the resident was not able to void on her own. The PICC line was utilized for blood draws and medications; however, upon discharge no orders were obtained to use the PICC line.</p> <p>During the initial tour of the facility on May 12, 2025, at 1030 a.m. the surveyor was speaking with Resident 126 and her family. The resident's family member indicated that they were concerned that the catheter and PICC line were still in place and that both were a source of possible infection. The family member stated that at one point in the hospital the catheter was out, but they had to reinsert it because she was unable to control her urine. The family member further indicated that she has addressed her concerns with several staff and did not get any resolution. Later that day the surveyor saw the family member in the hall and she was visibly upset/angry and crying. She indicated that she was unhappy about not getting answers about her concerns. She indicated that staff had previously told her the urology appointment was not until May 28th because the doctor was full. She felt this was too long to wait to see about getting the catheter out, and she has been wanting someone to look into it for her. Then again, she commented that she has had the same concern for the PICC line. She stated that she has been telling staff to address the need for it, that it is not being used and that she wants it out.</p> <p>Interview with Registered Nurse 1 on May 15, 2025, at 8:53 a.m. indicated that she spoke with Resident 126's family member regarding her concerns. Registered Nurse 1 informed the family member that the doctor makes rounds on Friday and that her concerns could be discussed with him at that time. She further indicated that in retrospect it would have been better for the resident and family if she would have contacted the physician at that time regarding the families concerns.</p> <p>Interview with the Director of Nursing on May 15, 2025, at 2:12 p.m. confirmed that staff should have contacted the physician in a more timely manner in order to provide clarification regarding the continued need for Resident 126's urinary catheter and PICC line.</p> <p>28 Pa. Code 211.12(d)(1)(3)(5) Nursing Services.</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>48941</p> <p>Based on review of clinical records, as well as staff interviews, it was determined that the facility failed to ensure that medications were provided as ordered by the physician for one of 49 residents reviewed (Resident 62).</p> <p>Findings include:</p> <p>A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 62, dated March 11, 2025, revealed that the resident was cognitively intact, required assistance for care needs, and had diagnoses that included hypertension.</p> <p>Physician's orders for Resident 62, dated April 30, 2024, included an order for the resident to receive 12.5 milligrams (mg) of metoprolol tartrate (treats hypertension) twice daily for hypertension. The medication was to be held if the resident's systolic blood pressure (the top number of a blood pressure reading) was 110 millimeters of mercury (mmHg) or less, or if the heart rate was less than 60 beats per minute.</p> <p>Physician's orders for Resident 62, dated April 8, 2025, included an order for the resident to receive 6.25 mg of metoprolol tartrate twice daily for hypertension. The medication was to be held if the resident's systolic blood pressure was 110 mmHg or less, or if the heart rate was less than 60 beats per minute.</p> <p>Review of Resident 62's Medication Administration Record (MAR) for February, March and April 2025 revealed that the resident's systolic blood pressure was less than 110 mmHg during the morning on March 2 and April 15, 2025, and during the evening on February 27 and April 11, 2025. There was no documented evidence that the metoprolol tartrate was held as ordered by the physician on the above-mentioned dates and times.</p> <p>Review of Resident 62's MAR for February, March and April 2025, as well as review of the clinical record, revealed no documented evidence that the resident's blood pressure or heart rate was obtained prior to administering the metoprolol tartrate during the morning on February 21 and during the evening on March 27 and April 22, 2025.</p> <p>Interview with the Director of Nursing on May 14, 2025, at 11:39 a.m. confirmed that Resident 62's metoprolol tartrate was not held as ordered by the physician on the above-mentioned dates and times and confirmed that the resident's blood pressure and heart rate were not obtained prior to administering the metoprolol tartrate on the above-mentioned dates and times.</p> <p>28 Pa. Code 211.12(d)(1)(5) Nursing services.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>31760</p> <p>Based on review of facility policies and clinical records, as well as staff interviews, it was determined that the facility failed to ensure that a resident's environment remained free of accident hazards by failing to ensure care-planned interventions were in place for one of 49 residents reviewed (Resident 17) who were at risk for falls, and failed to ensure that other residents' environment remained free of accident hazards from a resident with aggressive behaviors for one of 49 residents reviewed (Resident 93).</p> <p>Findings include:</p> <p>The facility's policy regarding fall prevention and management, dated January 31, 2025, indicated that the facility will identify those residents at risk for falls upon admission, readmission, and quarterly and provide appropriate interventions to modify and/or compensate for risk factors. The kardex, point of care and point of care tasks will reflect all safety devices utilized as ordered. The care plan will be updated to reflect resident-specific safety needs and interventions.</p> <p>A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 17, dated March 13, 2025, revealed that the resident was cognitively impaired, required substantial assistance for bed mobility, was dependent with transfers, had a fall with a major injury since the prior assessment, and had diagnoses that included Alzheimer's dementia.</p> <p>Physician's orders for Resident 17, dated November 14, 2024, included an order for staff to keep the resident's bed in the lowest position with landing strips beside the bed when the resident was in bed. The current fall risk care plan for Resident 17 included an intervention to keep the resident's bed in the lowest position with landing strips beside the bed when the resident was in bed.</p> <p>Observations of Resident 17 on May 12, 2025, at 12:20 p.m. revealed that the resident was in bed with a fall mat on the floor to the left of her bed. Her bedside table was to the right of her bed, and a fall mat was observed on the floor on the other side of bedside table, not on the floor beside her bed.</p> <p>Interview with Licensed Practical Nurse 2 on May 12, 2025, 12:32 p.m. confirmed that Resident 17's fall mat was not on the floor beside the right side of her bed. She stated that the fall mat was probably not at bedside because sometimes the bedside table is not easy to move on the fall mat.</p> <p>Interview with the Director of Nursing on May 12, 2025, at 3:47 p.m. confirmed that Resident 17's fall mat should have been next to the resident's bed on the right side.</p> <p>The facility's policy regarding dementia care, dated January 31, 2025, indicated that managing safety in residents living with dementia can be challenging secondary to cognitive impairment. Implementing interventions for safety are instituted on a case-by-case basis.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A quarterly MDS assessment for Resident 93, dated December 18, 2024, revealed that the resident was severely cognitively impaired, displayed physical behavioral symptoms directed towards others (e.g., hitting, kicking, pushing, scratching, grabbing, abusing others sexually) and other behavioral symptoms not directed towards others (e.g., physical symptoms such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily wastes, or verbal/vocal symptoms like screaming, disruptive sounds) which occurred one to three days during the review period, wandered which occurred daily, and had a diagnosis of dementia. A quarterly MDS assessment for Resident 93, dated March 19, 2025, revealed that the resident was severely cognitively impaired and wandered daily.</p> <p>A care plan for Resident 93, dated August 15, 2024, revealed that the resident was not able to make leisure choices. The resident's daughter stated that he does like listening to music, being outdoors, and conversing/being around others. She stated he does like to keep busy as he always thinks he is working. She stated that him doing things with groups of people was very important as he does like to be around others. Activities department will offer supportive visits, encourage independent leisure pursuits, and invite/assist in transporting to/from recreational programs of potential interest while respecting his right to decline. Staff was to offer diversional therapeutic tasks when the resident displays increased behaviors. Have different tasks available after 30 minutes if behaviors increase or do not change. Offer recreational programs and leisure activities that correlate to resident's interests such as music/Catholic programs, therapeutic tasks, outdoor activities, socials, some active games. A care plan, dated November 11, 2024, revealed that the resident has the potential for behaviors such as agitation with other residents causing confrontation episodes, as well as pacing and using the restroom in public places within the unit. Staff was to offer activities that will grab his attention, such as a movie. When the resident begins to pace it is usually an indication that he is getting increasingly agitated. Remove the resident from the area that might be causing the increased agitation; however, keep within eyesight of staff to allow to monitor behaviors. The resident was a mechanic and enjoys working with his hands, attempt to redirect with tasks that involve hand movement when able.</p> <p>A nursing note for Resident 93, dated August 20, 2024, revealed that the resident wandered all shift and has not sat down anywhere, yet. The resident was often seen pushing other residents in their wheelchairs and turning tray tables upside down and trying to disassemble them, etc. Tried to distract and redirect the resident and has not been successful as the resident has no interest in what staff was saying and no interest in food or drinks, as well as no interest in sitting, television, etc.</p> <p>Nursing notes for Resident 93, dated September 10, 2024, at 9:43 p.m. and September 11, 2024, at 8:59 p.m. revealed that the resident grabbed another resident's wrist and grabbed another resident's forearm.</p> <p>Nursing notes for Resident 93, dated October 12, through 22, 2024, revealed that the resident had been wandering into other residents' rooms and rummaging through their belongings, as well as pushing other residents in their wheelchairs.</p> <p>A nursing note for Resident 93, dated October 28, 2024, revealed that the resident was attempting to push a female resident in her wheelchair to the dining table. The female resident requested him to stop. The resident got agitated and wrapped his hands around her head and poked her right eye.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Nursing notes for Resident 93, dated November 4 through 7, 2024, revealed that the resident had been wandering into other residents' rooms and rummaging through their belongings.</p> <p>A nursing note for Resident 93, dated November 9, 2024, revealed that the resident was in another female resident's room, and it was believed that resident may have hit the female resident in the face. This was unwitnessed, but staff believes that they heard a pop as if from a punch and then saw female resident holding her face. Attempted to interview resident about the incident; however, the resident was cognitively unable to recall an event. An assessment was completed on both of resident's hands, as there was no way to know which hand was used. There were no visible injuries to either of resident's hands.</p> <p>A nursing note for Resident 93, dated November 14, 2024, revealed that the resident was found in another resident's room punching the other resident in their arm.</p> <p>A nursing note for Resident 93, dated December 14, 2024, revealed that the resident had episodes of wandering. The resident went up to a female resident and locked his hand with her and would not let go.</p> <p>Nursing notes for Resident 93, dated December 17, 2024, through March 24, 2025, revealed that the resident was wandering in and out of other residents' rooms, at times pushing other residents in their wheelchairs or urinating in other residents' rooms, as well as tinkering with stuff as if he was repairing the item.</p> <p>A nursing note for Resident 93, dated March 25, 2025, revealed that the resident attempted to take another resident's walker and attempted to push another resident in their wheelchair.</p> <p>A nursing note for Resident 93, dated April 1, 2025, revealed that the resident had punched another male resident in the face. The resident is not oriented and according to staff looked to be attempting to repair the other resident's wheelchair.</p> <p>Nursing notes for Resident 93, dated April 2, through 10, 2025, revealed that the resident had been wandering in and out of other residents' rooms.</p> <p>A nursing note for Resident 93, dated April 11, 2025, revealed that the resident was wandering the unit as usual. At one point he grabbed onto another resident's wheelchair on the wheel. The other resident told him to leave her wheelchair alone, but he would not let go. As the other resident tried to move away, the resident complained that this was hurting his hand. The resident's hand was removed from the wheelchair by staff, and the resident was reminded that the other resident does not want him touching her chair. The resident continued to grip the wheelchair and the nurse's wrist and became angry, saying You never let me do anything!</p> <p>A nursing note for Resident 93, dated May 4, 2025, revealed that the resident was pushing another resident in her wheelchair. The other resident had asked the Resident 93 to stop, but he continued to push. The other resident pushed back with her legs and Resident 93 pushed forward harder. The other resident had reached both of her hands back to slap Resident 93 in the face and did make contact. After the other resident slapped Resident 93, he drew his fist back like he was going to hit the other resident.</p> <p>(continued on next page)</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p>31760</p> <p>Based on review of facility policies, clinical records, as well as observations and staff interviews, it was determined that the facility failed to ensure that residents received proper care for indwelling urinary catheters for three of 49 residents reviewed who had an indwelling urinary catheter (Residents 55, 59, 106).</p> <p>Findings include:</p> <p>The facility's policy regarding indwelling urinary catheter (a flexible catheter used to drain urine from the bladder into a drainage collection bag) management, dated January 31, 2025, indicated to properly position the drainage bag below the level of the bladder to facilitate urine flow and avoid allowing the drainage bag or tubing to touch the floor.</p> <p>A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 55, dated April 17, 2025, revealed that the resident was understood, could usually understand others, and had an indwelling urinary catheter. A care plan for the resident, dated January 10, 2025, revealed that the resident had an indwelling urinary catheter, and staff was to position the indwelling urinary catheter bag and tubing below the level of the bladder.</p> <p>Observations of Resident 55 on May 12, 2025, at 10:59 a.m. revealed that the resident was sitting in his wheelchair in the hallway outside nurses' station on the fourth floor. His indwelling urinary catheter drainage bag was connected underneath his wheelchair in a privacy bag; however, the indwelling urinary catheter tubing was lying on the floor. The resident then began to self-propel in his wheelchair in the hallway with his indwelling urinary catheter tubing on the floor.</p> <p>Interview with Licensed Practical Nurse 3 on May 12, 2025, at 11:18 a.m. confirmed that Resident 55's indwelling urinary catheter tubing should not be on the floor.</p> <p>Interview with the Director of Nursing on May 13, 2025, at 1:05 p.m. confirmed that Resident 55's indwelling catheter tubing should not be on the floor.</p> <p>An admission MDS assessment for Resident 59, dated March 31, 2025, revealed that the resident was understood, could usually understand others, had an indwelling urinary catheter, and had diagnoses that included benign prostatic hyperplasia (enlarged prostate resulting in urinary problems). A care plan for the resident, dated March 26, 2025, revealed that the resident had an indwelling urinary catheter, and staff was to position the indwelling urinary catheter bag and tubing below the level of the bladder and away from the entrance room door.</p> <p>Observations of Resident 59, on May 14, 2025, at 9:21 a.m. revealed that the resident was lying in his bed watching television. His indwelling urinary catheter drainage bag was lying directly on the floor on the right side of the bed, visible upon entrance to the room.</p> <p>Interview with Nurse Aide 4 on May 14, 2025, at 9:47 a.m. confirmed that Resident 59's indwelling urinary catheter bag should not be on the floor.</p> <p>(continued on next page)</p>

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview with the Director of Nursing on May 14, 2025, at 3:54 p.m. confirmed that Resident 59's indwelling catheter should not be on the floor.</p> <p>A quarterly MDS assessment for Resident 106, dated April 24, 2025, revealed that the resident was cognitively intact and had an indwelling urinary catheter. A care plan for the resident, dated February 24, 2025, revealed that the resident had an indwelling urinary catheter, and staff were to position the indwelling urinary catheter bag and tubing below the level of the bladder.</p> <p>Observations of Resident 106 on May 12, 2025, at 10:56 a.m. revealed that the resident was sitting in her wheelchair in her room. Her indwelling urinary catheter drainage bag was connected underneath her wheelchair with half of the drainage bag hanging out of the dignity bag. The exposed part of the drainage bag and the indwelling urinary catheter tubing were lying in direct contact with the floor.</p> <p>Interview with Nurse Aide 5 on May 12, 2025, at 11:18 a.m. confirmed that Resident 106's indwelling urinary catheter drainage bag and the indwelling urinary catheter tubing should not have been in direct contact with the floor. She indicated that she hooked the bag under her wheelchair, but it slides off.</p> <p>Interview with the Director of Nursing on May 12, 2025, at 3:47 p.m. confirmed that Resident 106's indwelling urinary catheter drainage bag and the indwelling urinary catheter tubing should not have been in direct contact with the floor.</p> <p>The facility's policy regarding intake and output documentation, dated January 31, 2025, indicated that the purpose of the procedure was to accurately determine the amount of urine that a resident excretes in a 24-hour period.</p> <p>Current physician's orders for Resident 106, included an order for staff to measure the resident's urinary output every shift. A care plan for the resident, dated February 24, 2025, revealed that the resident had an indwelling urinary catheter, and staff were to monitor and document intake and output as per facility policy.</p> <p>Review of Resident 106's clinical record, for February, March, April and May 2025 revealed that there was no documented evidence that the resident's urinary output was measured on the following dates and shifts: February 23 and 25 on the night shift; March 1 and 12 on the night shift; March 3 on the day shift; March 22 and 30 on the evening shift; April 19 and 24 on the night shift; April 27 on the evening shift; and May 12 and 13 on the day shift.</p> <p>Interview with the Director of Nursing on May 14, 2025, at 12:53 p.m. confirmed that there was no documented evidence that Resident 106's urinary output was measured as per facility policy, per physician's orders, and per the care plan on the above-mentioned dates and shifts.</p> <p>28 Pa. Code 211.12(d)(3)(5) Nursing Services.</p>

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<p>F 0694</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide for the safe, appropriate administration of IV fluids for a resident when needed.</p> <p>48941</p> <p>Based on review of policies and clinical records, as well as staff interviews, it was determined that the facility failed to flush a peripherally-inserted central catheter (PICC, a long, thin tube that is inserted through a vein in the arm and passed through to the larger veins near the heart), and a midline (a thin soft tube that's inserted through a vein in the arm and passed through to where the tip is at or near armpit level) as ordered by the physician for one of 49 residents reviewed (Resident 96).</p> <p>Findings include:</p> <p>The facility's policy regarding flushing central venous and midline catheters, dated January 31, 2025, indicated to flush catheters at regular intervals to maintain patency.</p> <p>A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 96, dated March 31, 2025, indicated that the resident was cognitively intact, required assistance with care needs, received intravenous medications (medications delivered through a tube placed in a vein) while a resident, and had a diagnosis of anemia.</p> <p>Physician's orders for Resident 96, dated February 16, 2025, included an order for staff to flush the resident's midline with 10 milliliters (ml) of Normal Saline (NSS) every shift for preventative measures, midline maintenance.</p> <p>Review of Resident 96's Medication Administration Record (MARs), dated February and March 2025, revealed that there was no documented evidence that staff flushed the resident's midline with 10 ml of NSS during the day shift on March 7, during the evening shift on February 27 and March 17, and during the night shift on February 20 and 25, and March 5, 9, 10, 13, 14, 16, 17, 19 and 20.</p> <p>Physician's orders for Resident 96, dated March 22, 2025, included an order for staff to flush the resident's PICC with 10 ml of NSS every shift for PICC maintenance.</p> <p>Review of Resident 96's MARs, dated March, April and May 2025, revealed that there was no documented evidence that staff flushed the resident's PICC with the 10 ml of NSS during the day shift on April 22 and May 1; during the evening shift on March 22, 25 and 27; and during the night shift on April 8, 9, and 24, and May 8 and 13.</p> <p>Interview with the Director of Nursing on May 15, 2025, at 11:15 a.m. confirmed that there was no documented evidence that Resident 96's midline and PICC was flushed with the 10 ml of NSS every shift as per facility policy and as per the physician's orders on the above-mentioned dates and shifts.</p> <p>28 Pa. Code 211.12(d)(1)(5) Nursing Services.</p>		

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<p>F 0730</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observe each nurse aide's job performance and give regular training.</p> <p>38012</p> <p>Based on review of nurse aides' dates of hire and their most recent performance review dates, it was determined that the facility failed to complete annual nurse aide performance evaluations for two of three nurse aides reviewed (Nurse Aides 6, 7).</p> <p>Findings include:</p> <p>A list of nurse aides provided by the facility revealed that based on their months and days of hire, an annual performance evaluation was due in November 2024 for Nurse Aide 6 and in January 2025 for Nurse Aide 7. However, there was no documented evidence that annual performance evaluations were completed as required for Nurse Aides 6 and 7.</p> <p>Interview with the Nursing Home Administrator on May 14, 2025, at 12:51 confirmed that she could provide no evidence that annual performance evaluations were completed as required for Nurse Aides 6 and 7.</p> <p>28 Pa. Code 201.18(e)(1) Management.</p>

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<p>F 0744</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia.</p> <p>31760</p> <p>Based on review of facility policies and clinical record, as well as and staff interviews, it was determined that the facility failed to provide appropriate treatment and services for two of 49 residents reviewed (Residents 38, 93) who had dementia.</p> <p>Findings include:</p> <p>The facility's policy regarding dementia care, dated January 31, 2025, indicated that residents living with dementia may experience agitation, aggression, distress or psychosis. Consideration should be given to non-pharmacological interventions prior to instituting a pharmacological treatment. It is the intent to use the lowest effective dose and utilize for the shortest time possible.</p> <p>A significant change in status Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 38, dated February 21, 2025, revealed that the resident was severely cognitively impaired, exhibited verbal behavioral symptoms directed towards others (e.g., threatening others, screaming at others, cursing at others) which occurred one to three days, and had a diagnosis which included Alzheimer's disease and adjustment disorder with mixed anxiety and depressed mood. A care plan for the resident, dated February 21, 2025, revealed that the resident chooses to spend most of his leisure time watching some television and listening to music on the lane. He will partake in some group activities as desired such as music programs, outdoor activities when it is nice outside, and some socials at times. Activities department will offer supportive visits, encourage independent leisure pursuits, and invite/assist in transporting to/from recreational programs of potential interest while respecting his right to decline. A care plan, dated June 27, 2023, revealed that the resident displays behaviors of wandering, being agitated with staff/in general, refusing care, rummaging through other residents' items, peeing on the floor, and calling 911 related to Alzheimer's disease, mood disorder, and insomnia. His behaviors may be triggered by disorientation to place.</p> <p>A nursing note for Resident 38, dated September 27, 2024, revealed that the resident was anxious and restless. He was pacing the unit and upset with other residents because he believes they were his employees, and they are not listening to him. He told some of the residents that they were fired and they needed to leave.</p> <p>A nursing note for Resident 38, dated October 12, 2024, revealed that the resident was agitated at the beginning of the shift due to the bar still being open and people were passed out at the bar. The resident was restless and wandering into other residents' rooms. The resident got irritated with staff and other residents that did not help him try to find a car.</p> <p>A nursing note for Resident 38, dated October 16, 2024, revealed that the resident was agitated and anxious. He was wandering the hall, in and out of other residents' rooms. He was taking other residents' cloths and putting them on. He went into another resident's room and emptied the closet and dresser onto the floor and beds.</p> <p>(continued on next page)</p>		

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<p>F 0744</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A nursing note for Resident 38, dated October 17, 2024, revealed that the resident was pleasant throughout shift until bedtime. He got into a female resident's bed and would not get out of her bed. He was vulgar with staff, and he then spent the next hour pacing the hallways attempting to go into other residents' rooms.</p> <p>Nursing notes for Resident 38, dated October 31, 2024, through November 30, 2024, revealed that the resident was agitated and anxious at times wandering into other residents' rooms and messing with their belongings.</p> <p>Nursing notes for Resident 38, dated December 8, 2024, through December 27, 2024, revealed that the resident was agitated and anxious at times wandering into other residents' rooms and messing with their belongings. He was even caught wearing other residents' clothing.</p> <p>Nursing notes for Resident 38, dated January 1, through 21, 2025, revealed that the resident had been wandering in and out of other residents' rooms looking for something to do.</p> <p>There was no documented evidence that any new interventions were attempted to address Resident 38's wandering except to have his medications adjusted.</p> <p>Interview with the Director of Nursing on May 15, 2025, at 10:25 a.m. confirmed that there was no documented evidence that any new interventions were attempted to address Resident 38's wandering except to have his medications adjusted.</p> <p>A quarterly MDS assessment for Resident 93, dated December 18, 2024, revealed that the resident was severely cognitively impaired, displayed physical behavioral symptoms directed towards others (e.g., hitting, kicking, pushing, scratching, grabbing, abusing others sexually), and other behavioral symptoms not directed towards others (e.g., physical symptoms such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily wastes, or verbal/vocal symptoms like screaming, disruptive sounds) which occurred one to three days during the review period, wandered which occurred daily, and had a diagnosis which included dementia.</p> <p>(continued on next page)</p>		

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<p>F 0744</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A quarterly MDS assessment for Resident 93, dated March 19, 2025, revealed that the resident was severely cognitively impaired and wandered daily. A care plan for the resident, dated August 15, 2024, revealed that the resident was not able to make leisure choices. The resident's daughter stated that he does like listening to music, being outdoors, and conversing/being around others. She stated he does like to keep busy as he always thinks he is working. She stated that him doing things with groups of people was very important as he does like to be around others. Activities department will offer supportive visits, encourage independent leisure pursuits, and invite/assist in transporting to/from recreational programs of potential interest while respecting his right to decline. Staff was to offer diversional therapeutic tasks when resident displays increased behaviors. Have different tasks available after 30 minutes if behaviors increase or do not change. Offer recreational programs and leisure activities that correlate to resident's interests such as music/Catholic programs, therapeutic tasks, outdoor activities, socials, some active games. A care plan, dated November 11, 2024, revealed that the resident has the potential for behaviors such as agitation with other residents causing confrontation episodes, as well as pacing and using the restroom in public places within the unit. Staff was to offer activities that will grab his attention, such as a movie. When the resident begins to pace that is usually an indication that he is getting increasingly agitated, remove the resident from the area that might be causing the increased agitation; however, keep within eyesight of staff to allow to monitor behaviors. The resident was a mechanic and enjoys working with his hands, attempt to redirect with tasks that involve hand movement when able.</p> <p>A nursing note for Resident 93, dated August 20, 2024, revealed that the resident wandered all shift. That he has not sat down anywhere, yet. The resident was often seen pushing other residents in their wheelchairs, turning tray tables upside down and trying to disassemble them, etc. Tried to distract and redirect the resident and has not been successful as the resident has no interest in what staff was saying, and no interest in food or drinks, as well as no interest in sitting, T.V., etc.</p> <p>Nursing notes for Resident 93, dated September 10, 2024, at 9:43 p.m. and September 11, 2024, at 8:59 p.m. revealed that the resident grabbed another resident's wrist and grabbed another resident's forearm.</p> <p>Nursing notes for Resident 93, dated October 12 through 22, 2024, revealed that the resident had been wandering into other residents' rooms and rummaging through their belongings, as well as pushing other residents in their wheelchairs.</p> <p>Nursing notes for Resident 93, dated November 4 through 7, 2024, revealed that the resident had been wandering into other residents' rooms and rummaging through their belongings.</p> <p>A nursing note for Resident 93, dated December 14, 2024, revealed that the resident had episodes of wandering. The resident went up to a female resident and locked his hand with her and would not let go.</p> <p>Nursing notes for Resident 93, dated December 17, 2024, through March 24, 2025, revealed that the resident was wandering in and out of other residents' rooms, at times pushing other residents in their wheelchairs or urinating in other residents' rooms, as well as tinkering with stuff as if he was repairing the item.</p> <p>A nursing note for Resident 93, dated March 25, 2025, revealed that the resident attempted to take another resident's walker and attempted to push another resident in their wheelchair.</p> <p>(continued on next page)</p>		

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<p>F 0744</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Nursing notes for Resident 93, dated April 2 through 10, 2025, revealed that the resident had been wandering in and out of other residents' rooms.</p> <p>A nursing note for Resident 93, dated April 11, 2025, revealed that the resident was wandering the unit as usual. At one point he grabbed onto another resident's wheelchair on the wheel. The other resident told him to leave her wheelchair alone, but he would not let go. As the other resident tried to move away, the resident complained that this was hurting his hand. The resident's hand was removed from the wheelchair by staff, and the resident was reminded that the other resident does not want him touching her chair. The resident continued to grip the wheelchair, and the nurse's wrist and became angry, saying You never let me do anything!</p> <p>There was no documented evidence that any new interventions were attempted to address Resident 93's wandering except to have his medications adjusted, and a hospital admission from November 14, 2024, through December 15, 2024, for his increased behaviors.</p> <p>Interview with the Director of Nursing on May 14, 2025, at 2:05 p.m. confirmed that there was no documented evidence that any new interventions were attempted to address Resident 93's wandering except to have his medications adjusted, and a hospital admission from November 14, 2024, through December 15, 2024, for his increased behaviors.</p> <p>28 Pa. Code 211.12(d)(5) Nursing Services.</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>48941</p> <p>Based on review of clinical records, as well as staff interviews, it was determined that the facility failed to maintain accountability for controlled medications (drugs with the potential to be abused) for one of 49 residents reviewed (Resident 62).</p> <p>Findings include:</p> <p>A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 62, dated March 11, 2025, revealed that the resident was cognitively intact, required assistance for care needs, and was taking an opioid medication (medications with the potential to be abused used to treat pain).</p> <p>Physician's orders for Resident 62, dated January 27, 2025, included an order for the resident to receive 50 milligrams (mg) of Tramadol (a narcotic pain medication) every six hours as needed for moderate to severe pain.</p> <p>Review of the controlled drug record (a form that accounts for each tablet/pill/dose of a controlled drug) for Resident 62, dated February, March and April, 2025, revealed that a 50 mg tablet of Tramadol was signed out on February 22 at 7:00 p.m.; March 1 at 7:22 p.m.; March 7 at 7:30 p.m.; March 9 at 7:45 p.m.; April 5 at 7:30 p.m. and April 7 at 7:15 p.m. However, there was no documented evidence in Resident 62's clinical record, including the Medication Administration Record (MAR), that the signed-out doses of Tramadol were administered to the resident on the above-mentioned dates and times.</p> <p>Interview with the Director of Nursing on May 15, 2025, at 11:15 a.m. confirmed that there was no documented evidence in Resident 62's clinical record to indicate that the signed-out doses of Tramadol were administered to the resident on the above-mentioned dates and times.</p> <p>28 Pa. Code 211.9(a)(1) Pharmacy Services.</p> <p>28 Pa. Code 211.12(d)(1)(3)(5) Nursing Services.</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>41233</p> <p>Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.</p> <p>Based on a review of facility policies and information provided by the facility, as well as observations and staff interviews, it was determined that the facility failed to serve food items at appetizing temperatures.</p> <p>Findings include:</p> <p>The facility's policy regarding temperatures for safe food handling, dated January 31, 2024, revealed that the temperatures of all food items will be taken and properly recorded prior to service of each meal. All hot food items must be cooked to appropriate internal temperatures, held and served at a temperature of at least 135 degrees Fahrenheit (F). All cold food items must be stored and served at a temperature of 41 degrees F or below.</p> <p>An interview with Resident 51 on May 12, 2025, at 1:10 p.m. indicated that his meals are often cold when his tray arrives. His room was toward the end of the hall and he indicated that it is often one of the last trays delivered.</p> <p>Observations of the lunch meal service in the main kitchen on May 13, 2024, revealed that the second north unit cart containing a test tray left the main kitchen at 12:30 p.m. and arrived on north unit at 12:31 p.m. Trays were passed to the residents that were in their rooms beginning at 12:41 p.m. and the last resident was served at 12:57 p.m. The test tray was removed from the cart at 12:59 p.m. and the temperature of the soda was 51.5 degrees F, the chicken was 131.5 degrees F, the carrots were 125.4 degrees F, and the potatoes were 133.8 degrees F. The soda was warm and the chicken, carrots and potatoes were cold and not at a palatable or appetizing temperature.</p> <p>A council meeting with approximately ten residents was held on May 14, 2025. They indicated that it took too long to get their food, and when it did arrive it was often cold.</p> <p>Interview with the Dietary Director at the time of observation confirmed that the soda, chicken, carrots and potatoes on the test tray, were not at an appetizing temperature.</p> <p>28 Pa. Code 201.18(b)(1)(2)(e) Management.</p> <p>28 Pa. Code 211.6(c) Dietary Services.</p>		

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<p>F 0867</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action.</p> <p>48941</p> <p>Based on review of the facility's plans of correction and the results of the current survey, it was determined that the facility's Quality Assurance Performance Improvement (QAPI) committee failed to correct quality deficiencies and ensure that plans to improve the delivery of care and services effectively addressed recurring deficiencies.</p> <p>Findings include:</p> <p>The facility's deficiencies and plans of corrections for State Survey and Certification (Department of Health) survey ending June 27, 2024, revealed that the facility developed plans of correction that included quality assurance systems to ensure that the facility maintained compliance with cited nursing home regulations. The results of the current survey, ending May 15, 2025, identified repeated deficiencies related to failure to develop and implement comprehensive care plans, failure to provide quality of care, failure to provide a safe environment that is free of accident hazards, failure to provide appropriate treatment and services for residents with dementia, and failure to maintain compliance with the regulation regarding infection control.</p> <p>The facility's plans of correction for deficiencies regarding developing and implementing comprehensive care plans, cited during the survey ending June 27, 2024, revealed that the facility would complete audits and report the results of the audits to the QAPI committee for review. The results of the current survey, cited under F656, revealed that the facility's QAPI committee failed to successfully implement their plan to ensure ongoing compliance with the regulation regarding developing and implementing comprehensive care plans.</p> <p>The facility's plan of correction for a deficiency regarding quality of care, cited during the survey ending June 27, 2024, revealed that the facility developed a plan of correction that included completing audits and reporting the results of the audits to the QAPI committee for review. The results of the current survey, cited under F684, revealed that the facility's QAPI committee failed to successfully implement their plan to ensure ongoing compliance with regulations regarding quality of care.</p> <p>The facility's plans of correction for deficiencies regarding a safe environment that is free of accident hazards, cited during the survey ending June 27, 2024, revealed that the facility developed plans of correction that included completing audits and reporting the results of the audits to the QAPI committee for review. The results of the current survey, cited under F689, revealed that the facility's QAPI committee failed to maintain compliance with the regulation regarding a safe environment that is free of accident hazards.</p> <p>The facility's plan of correction for a deficiency regarding appropriate treatment and services for residents with dementia, cited during the survey ending June 27, 2024, revealed that the facility developed a plan of correction that included completing audits and reporting the results of the audits to the QAPI committee for review. The results of the current survey, cited under F744, revealed that the facility's QAPI committee failed to successfully implement their plan to ensure ongoing compliance with regulations regarding appropriate treatment and services for residents with dementia.</p> <p>(continued on next page)</p>		

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 05/15/2025
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.			
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<p>F 0867</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The facility's plans of correction for deficiencies regarding infection control, cited during the surveys ending June 27, 2024, revealed that the facility developed plans of correction that included completing audits and reporting the results of the audits to the QAPI committee for review. The results of the current survey, cited under F880, revealed that the facility's QAPI committee failed to maintain compliance with the regulation regarding infection control.</p> <p>Refer to F656, F684, F689, F744, F880.</p> <p>28 Pa. Code 201.14(a) Responsibility of Licensee.</p> <p>28 Pa. Code 201.18(e)(1) Management.</p>		

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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>41233</p> <p>Based on review of policies and clinical records, as well as observations and staff interviews, it was determined that the facility failed to maintain their infection prevention and control program for hand hygiene during wound care for one of 49 residents reviewed (Resident 59).</p> <p>Findings include:</p> <p>The facility's policy regarding hand hygiene, dated January 31, 2025, indicated that hand hygiene is an important infection control measure to prevent illness in skilled nursing homes, and that hands should be sanitized or washed before and after the use of gloves.</p> <p>An admission Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 59, dated March 31, 2025, indicated that the resident was understood and able to understand others. Physician's orders for Resident 59, dated May 7, 2025, included an order to cleanse the right heel surgical wound thoroughly with Vashe (a wound cleanser) and gauze. Apply silver calcium alginate (a type of silver infused wound dressing) on the wound bed, then cover with an ABD and wrap with kerlix and tape; perform daily and as needed. A care plan for the resident, dated April 26, 2025, revealed that the resident had impaired skin integrity related to multiple surgical wounds.</p> <p>Observations on May 15, 2025, at 8:36 a.m. revealed that Licensed Practical Nurse 8 donned a gown and gloves and with scissors she removed Resident 59's right heel dressing; then without removing her gloves and performing hand hygiene, she cleansed the area with Vashe and gauze. She then applied silver calcium alginate to the wound bed, covered the area with an ABD and wrapped kerlix (gauze) around the resident's heel, and taped the dressing closed. She then gathered her garbage, removed her gloves, and washed her hands.</p> <p>Interview with Licensed Practical Nurse 8 on May 15, 2025, at 8:36 a.m. confirmed that while performing wound care on Resident 59, she removed the soiled dressing and without changing her gloves and hand sanitizing, she went on to perform clean wound care.</p> <p>Interview with the Director of Nursing on May 15, 2025, at 10:25 a.m. confirmed that Licensed Practical Nurse 8 should have removed her gloves, sanitized her hands, and donned new gloves after removing the old dressing and before placing the new one.</p> <p>28 Pa. Code 211.12(d)(1)(5) Nursing Services.</p>		

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<p>F 0908</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Keep all essential equipment working safely.</p> <p>41233</p> <p>Based on review of policies and cleaning schedules/documents, as well as observations and staff interviews, it was determined that the facility failed to ensure that essential kitchen equipment was maintained in a safe operating condition.</p> <p>Findings include:</p> <p>The facility's policy regarding routine stovetop cleaning, dated January 31, 2025, indicated that in order to keep all equipment at optimal levels of functioning and cleanliness, a routine cleaning schedule would be followed.</p> <p>Observations of the kitchen stove top on May 12, 2025, at 9:46 a.m. and May 13, 2025, at 8:38 a.m. and 1:37 p.m., revealed that there was a thick accumulation of black grease on and around four out of six stove top burners. These burners were located next to the grill area on the stovetop.</p> <p>Review of the kitchen cleaning schedule for April and May 2025 indicated that the stovetop was to be cleaned monthly.</p> <p>Interview with the Dietary Manager on May 14, 2025, at 11:08 a.m. confirmed that there was a large accumulation of heavy grease on and around four of the stovetop burners. She indicated that on April 1, 2025, the stovetop was cleaned and that it should have been cleaned again on May 1, 2025 and it was not.</p> <p>28 Pa. Code 201.18(e)(6) Management.</p> <p>28 Pa. Code 211.6(c) Dietary Services.</p>