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	04/30/2026

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 0742 Level of Harm - Actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder. Based on clinical record reviews and staff interviews, it was determined that the facility failed to implement interventions to prevent physical and verbal behaviors, and/or failed to develop and implement new interventions to address ongoing physical and verbal behaviors for two of 44 residents reviewed (Residents 8, 68) resulting in psychosocial harm for one resident (Resident 68). Findings include: A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 8, dated March 31, 2026, indicated that the resident was severely cognitively impaired, had verbal behaviors directed at others 1-3 days, and had diagnoses that included dementia. A behavior care plan, most recently revised April 3, 2026, revealed that staff were to identify triggers and what de-escalates behavior; address and anticipate her needs; monitor danger to herself and others; offer stuffed animal when she is agitated; and to use activities to assist with behaviors. An admission MDS assessment for Resident 68, dated January 15, 2026 revealed that the resident was cognitively intact and had no behaviors. A nursing note for Resident 8, dated December 19, 2026 revealed that the resident was holding a stuffed bear and that staff took the bear from her and told her that the bear belonged to everyone, not just her. A nursing note for Resident 8, dated February 28 2026 revealed that she was blocking the walkway to the bathroom in her room preventing her roommate, Resident 68, from getting through. Resident 68 had to ring for assistance to help her get to the bathroom. A nursing note for Resident 8, dated March 14, 2026 revealed that she was arguing with her roommate, Resident 68 and had to be redirected away from her. A psychiatric provider note for Resident 68, dated March 17, 2026 revealed that the resident told the provider that her roommate, Resident 8, hits her and gets into her things. A nursing note for Resident 8, dated March 21, 2026 revealed that she was upset because her roommate, Resident 68 was in her room. A nursing note for Resident 8, dated March 27, 2026 revealed that she attacked her roommate, Resident 68, due to Resident 68 being on her side of the room, which she needed to go through to get to the bathroom. Resident 8 was the aggressor. Resident 8 scratched Resident 68's face and left red marks on Resident 68's face. Resident 8 required anti-anxiety medication to calm her. A nursing note for Resident 68, dated March 27, 2026 revealed that the resident's boyfriend called the facility concerned that the resident was in an altercation with her roommate, Resident 8. A nursing note for Resident 8, dated April 11, 2026 revealed that the resident and her roommate, Resident 68, were shouting at each other and that Resident 8 became very anxious. Resident 8 required an anti-anxiety medication to calm her down. A nursing note for Resident 8, dated April 16, 2026 revealed that Resident 8's psychiatric medications were increased due to her behaviors. A physician's note, dated April 17, 2026 revealed that Resident 8 wheeled herself to the nurse's station and was yelling that she was going to do more than hit the bitch (Resident 68). Resident 8 struck her roommate, Resident 68, with a baby doll and kicked her. Resident 8 was agitated and having vocal outburst. Staff attempted to keep the residents separated, however, Resident 8 continued to swat at staff and attempted to get back to her room and Resident 68. Resident 8 was sent to the hospital and committed involuntarily to the psychiatric unit for her aggression and violent behaviors. A nursing note, dated April 24, 2026 for (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
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F 0742 Level of Harm - Actual harm Residents Affected - Few	Resident 8 revealed that she returned to the nursing facility on that date, to the same room she was previously in and with Resident 68 as her roommate. A nursing note for Resident 68, dated April 24, 2026 revealed that she was shaking and stated I'm sorry I'm shaking so bad, I'm just so scared to death with her (Resident 8) being in here and she pointed at Resident 8. According to the facility's census information, undated, Resident 8 and Resident 68 spent April 24, 2026 in the same room and the residents were not placed in separate rooms until April 25, 2026. There was no documented evidence that Resident 8's behaviors toward Resident 68 were assessed to determine if there were any patterns and/or precipitating factors that caused them. There was also no documented evidence that staff monitored the resident's behaviors, and no documented evidence that the interventions on the resident's behavior care plan were revised or that new interventions were developed to address the resident's ongoing behaviors. Further, there was no documented evidence that the residents were separated from the same room until April 25, 2026. Interview with Nurse Aide 2 on April 30, 2026 at 2:25 p.m. revealed that Resident 8 believes everything in the facility is her property and is difficult to redirect. Interview with the Social Services Director, the Assistant Director of Nursing and the Director of Nursing on April 30, 2026 at 2:58 p.m. revealed that Residents 8 and 68 were not separated because the facility was bed locked and there was no where within the locked unit to move them to. They confirmed that documentation revealed that Resident 68 was afraid of Resident 8, that Resident 8 was aggressive and violent to Resident 68, and that they were not separated until April 25, 2026. 28 Pa. Code 211.12(d)(5) Nursing services.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on review of policies and clinical records, as well as staff interviews, it was determined that the facility failed to ensure that non pharmalogical interventions were attempted prior to the administration of a psychotropic medication for one of 44 residents reviewed (Resident 75).Findings include:The facility's policy regarding use pf psychotropic medications, February 27, 2026, indicated that psychotropic medications were used to treat the resident's medical symptoms and maximize the resident's functional potential and well-being while minimizing the hazards associated with psychoactive drug side effects.An admission Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 75, dated March 13, 2026, revealed that the resident was cognitively intact, was taking an anti-anxiety medication, and had a diagnosis of anxiety. A care plan, dated March 12. 2026, indicated that staff were to attempt non-pharmalogical interventions such as diversional activities, rest, snacks, etc., prior to administering as needed psychotropics.Physician's orders for Resident 75, dated February 18 and 22, March 1, 9, 20 2026, included orders for the resident to be administered 1 milligram (mg) of lorazepam as needed for anxiety.A review of the medication administration records (MAR) for Resident 75, dated February and March 2026, revealed the resident was administered 1.0 mg of lorazepam on February 20, 22, 24, 26-28, and on March 1-3, 10-15, 18-26, and 28-30, 2026.There was no documented evidence that non-pharmacological interventions were attempted prior to the administration of lorazepam.Interview with the Director of Nursing on April 30, 2026, at 2:52 p.m. confirmed that there were no non-pharmacological interventions attempted prior to the administration of lorazepam for the dates listed above, and there should have been. 28 Pa. Code 211.9(a)(1)(k) Pharmacy services28 Pa. Code 211.12(c)(d)(1)(3)(5) Nursing services

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on review of policies and clinical records, as well as staff interviews, it was determined that the facility failed to ensure that physician's orders were followed for three of 44 residents reviewed (Residents 6, 8, 11) and failed to ensure that laboratory test results for monitoring anticoagulant medications were reported to the physician which resulted in a delay in treatment for one of 44 residents reviewed (Resident 123). Findings include: A quarterly Minimum Data Set (MDS) assessment (a federally mandated assessment of a resident's abilities and care needs) for Resident 6, dated February 6, 2026, revealed that the resident was cognitively impaired, was dependent on staff for daily care needs, received insulin (medication that lowers blood sugar levels), and had diagnoses that included diabetes. Physician's orders for Resident 6, dated December 10, 2025, included an order for the resident to receive Novolog Solution 100 unit/ml subcutaneously, according to a sliding scale (the amount of insulin is based on the result of a fingerstick blood sugar test) two times a day (scheduled for 6:30 a.m. and 6:30 p.m.). The sliding scale included giving 0 units of insulin for a blood sugar of 70-200 milligrams/deciliter (mg/dl), 3 units for a blood sugar of 201-250 mg/dl, 4 units for a blood sugar of 251-300 mg/dl, 5 units for a blood sugar 301-350 mg/dl, 6 units for a blood sugar of 351-400 mg/dl, 6 units for a blood sugar of 401-999 mg/dl and to notify the physician for further orders. Resident 6's Medication Administration Record (MAR) for January, February and April 2026, revealed that the residents blood sugar results were between 401-999 mg/dL at 4:30 p.m. on January 7, 20 and 21, February 18 and 25, April 7, 15, 17, 22 and 28, 2026. There was no documented evidence that the physician was notified that the resident's sliding scale blood sugar results were between 401-999 mg/dl on the dates and times mentioned. Interview with the Director of Nursing April 29, 2026, at 3:08 p.m. confirmed that the physician should have been notified when Resident 6's sliding scale results were 401 mg/dL or greater. The facility's medication administration policy, dated February 27, 2026, indicated that medications were to be administered in a safe and timely manner as prescribed by the physician. Physician's orders for Resident 8, dated April 24, 2026, included an order for the resident to receive 12 micrograms/hour Fentanyl patch (a narcotic pain medication), and to change the patch every 72 hours. A nursing note for Resident 8, dated April 24, 2026 at 2:24 p.m. revealed that the dose of the resident's Fentanyl patch was decreased and that a new patch was applied on dayshift that day. A nursing note for Resident 8, dated April 24, 2026 at 5:08 p.m. revealed that the resident was found to have two Fentanyl patches on and that one was removed and destroyed. Interview with the Director of Nursing on April 30, 2026 at 5:39 p.m. revealed that the nurse should have looked for an old Fentanyl patch on Resident 8 prior to placing a new patch on her. Physician's orders for Resident 11, dated September 12, 2025, included an order for the resident to receive Humalog Injection Solution 100 unit/ml subcutaneously, according to a sliding scale three times a day (scheduled for 6:00 a.m., 12:00 p.m., 6:00 p.m.). The sliding scale included giving 0 units of insulin for a blood sugar of 70-150 milligrams/deciliter (mg/dl), 1 unit for a blood sugar of 151-199 mg/dl, 2 units for a blood sugar of 200-249 mg/dL, 3 units for a blood sugar 250-299 mg/dl, 4 units for a blood sugar of 300-349 mg/dl, 5 units for a blood sugar of 350-399 mg/dl, 5 units for a blood sugar 400-600 mg/dl and to notify the physician for further orders. Resident 11's Medication Administration Record (MAR) for March and April 2026 revealed that the residents blood sugar results were between 400-600 mg/dL at 12:00 p.m. on March 20, 22 and 23, 2026; at 6:00 p.m. on March 11, 15 and 18, April 3, 24 and 25, 2026. There was no documented evidence that the physician was notified that the resident's sliding scale blood sugar results were between 400-600 mg/dl on the dates and times mentioned. Interview with the Director of Nursing April 29, 2026, at 3:08 p.m. confirmed that the physician should have been notified when Resident 11's sliding scale results were 400 mg/dL or greater. The facility policy for laboratory tests, dated February 27, 2016, indicated that the physician would be notified immediately if a test was obtained to monitor the blood level of a medication and the level was reported as high (above therapeutic range) or toxic. The nurse would notify the (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	physician promptly and would not give the next dose until the situation had been reviewed with the physician. An admission MDS assessment for Resident 123, dated February 24, 2026, revealed the resident was cognitively impaired, received anticoagulant medication (used to thin blood), and had a diagnosis of heart failure. The resident's care plan, dated March 3, 2026, indicated that he was at risk for bleeding due to anticoagulant therapy, and ordered labs were to be scheduled, results reviewed, and the results reported to the physician. Physician's orders for Resident 123, dated March 12, 2026, included an order for the resident to receive 7.0 mg of Coumadin (medication that thins the blood) at bedtime due to a prosthetic heart valve. The resident was also ordered to have blood drawn for prothrombin time and international normalized ratio (PT/INR - blood tests that determine how long it takes the blood to clot) to monitor the therapeutic levels (appropriate range) of Coumadin to be completed on March 19, 2026. A review of the clinical records for Resident 123, including nursing notes and a laboratory report, dated March 19, 2026, revealed the resident's PT/INR was 16.8/1.45, and there was no documented evidence that the physician was notified of the PT/INR results. A physician's order, dated April 20, 2026, included an order to obtain a PT/INR on April 20, 2026. A laboratory report, dated April 20, 2026, revealed the resident's PT/INR was 16.7/1.44 and physician's orders were received to increase the resident's Coumadin from 7 mg to 10 mg at bedtime, and to recheck the PT/INR on April 22, 2026. Interview with the Director of Nursing on April 30, 2026, at 12:38 p.m. confirmed that the physician was not notified of the results of the PT/INR obtained on March 19, 2026. 28 Pa. Code 211.12(d)(1)(5) Nursing services.

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide for the safe, appropriate administration of IV fluids for a resident when needed. Based on review of policies and clinical records, as well as staff interviews, it was determined that the facility failed to flush an intravenous (IV) line as ordered by the physician for one of 44 residents reviewed (Resident 134).Findings include:The facility's policy regarding catheter (a tube placed in a vein that can be used to deliver fluids and/or medications) insertion and care, dated February 7, 2026, indicated that midline and central line access devices were to be flushed to maintain patency; to prevent mixing of incompatible medications and solutions; and to ensure entire dose of solution or medication was administered into the venous system. A 10 milliliter (ml) saline flush (a method used to clean a catheter of blood or medication) was to be administered before and after each medication that was infused.An admission Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 134, dated March 18, 2026, indicated that the resident was cognitively intact, received an antibiotic, and IV medications.A nursing note, dated March 12,2026, at 4:27 p.m. revealed that the resident was admitted to the facility and had a PICC line to her right upper extremity. Physician's orders, dated March 11 and 12, 2026, included orders for resident's PICC line be flushed with 10 mL of normal saline before and after medication administration, a maintenance flush every shift, and to administer 650 milligrams (mg) of Daptomycin (antibiotic) intravenously for every 24 hours for infection.Resident 134's Medication Administration Record (MAR) for March and April 2026 revealed that the resident received 650 mg of Daptomycin from March 13 to 28, 2026; however, there was no documented evidence that Resident 134's PICC line was flushed every shift as ordered on March 12, 15, 16, 23, 24-29, and 31, 2026, and April 2, 7, 9, 10, 16-18, 23, and 26, 2026. Interview with the Director of Nursing on April 30, 2026, at 2:10 p.m. confirmed that there was no documented evidence that Resident 134's PICC line was flushed every shift as ordered.28 Pa. Code 211.12(d)(5) Nursing Services.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. Based on review of facility policies and clinical records, as well as staff interviews, it was determined that the facility failed to ensure that it was free from significant medication errors for two of 44 residents reviewed (Residents 19, 145).Findings include:The facility's policy regarding medication administration, dated February 27, 2026, indicated that the facility was to administer medications in accordance with written orders, including dosage, frequency, and parameters.An admission Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 19, dated April 20, 2026, revealed that the resident was moderately cognitively impaired, needed extensive assistance for daily care needs, had a multi-drug resistant organism, and had pressure ulcers.Physician's orders for Resident 19, dated April 21, 2026, included an order for the resident to receive 500 milligrams (mg) of Cefadroxil (an antibiotic) every twelve hours for an infection until May 1, 2026.A review of Resident 19's Medication Administration Record (MAR) for April 2026 revealed no documented evidence that a dose of Cefadroxil was administered on April 22 at 8:00 a.m., April 23 at 8:00 p.m., April 24 at 8:00 a.m. and 8:00 p.m., and April 28, 2026, at 8:00 p.m. Nursing notes, dated April 22 at 7:38 a.m., and April 24, 2026, at 10:45 a.m. and 8:30 p.m. revealed that the Cefadroxil was not available from the pharmacy.An interview with the Director of Nursing on April 30, 2026, at 10:42 a.m. confirmed that there was no documented evidence that Resident 19 received the ordered doses of Cefadroxil on the dates and times mentioned above. Physician's orders for Resident 145, dated April 24, 2026, included orders for the resident to receive 2 grams of Ampicillin intravenously every four hours related to an infected joint prosthesis for six weeks.A review of Resident 19's Medication Administration Record (MAR) for April 2026 revealed no documented evidence that a dose of Ampicillin was administered on April 24 at 9:00 p.m., April 26 at 5:00 a.m., April 27 at 9:00 p.m., April 28 at 5:00 a.m., 5:00 p.m. and 9:00 p.m., and April 29, 2026, at 1:00 a.m. and 5:00 a.m.An interview with the Director of Nursing on April 29, 2026, at 3:27 p.m. confirmed that there was no documented evidence that Resident 145 received the ordered doses of Ampicillin on the dates and times mentioned above.28 Pa. Code 211.12(d)(1)(3)(5) Nursing services.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on review of policies, as well as observations and interviews with residents and staff, it was determined that the facility failed to serve food that was palatable and at proper temperatures. Findings include: The facility's policy regarding meal service, dated February 27, 2026, revealed that food temperatures at point of service to the resident would be monitored according to palatability and maintained according to the guidelines set forth by the Food Safety Guidelines of the Food and Drug Association which state hot foods served to the resident would be palatable served at least 135 degrees Fahrenheit (F) or higher. Interview with Resident 2 on April 27, 2026, at 11:17 a.m. revealed that the food was terrible tasting, cold and he did not like it at all. Interview with Resident 70 on April 27, 2026 at 2:23 p.m. revealed that the resident disliked the food and that it was usually cold. He stated that he does not ask the staff to reheat it because they do not have time. Interview with Resident 84 on April 27, 2026, at 11:45 a.m. revealed that the food was not always warm. Review of the menu for the lunch meal on Wednesday, April 29, 2026, revealed that residents were to receive meatloaf with ketchup glaze, Au gratin potatoes, creamed peas, and chocolate eclairs. Tomato soup was available and served to taste. Observations in the kitchen on April 29, 2026, at 11:54 p.m. revealed that a test tray was placed on the lunch meal cart going to the second floor and parked against the wall until the second cart for the second floor was loaded with meal trays. The cart arrived on the unit at 12:02 p.m., staff passed the meal trays out leaving the doors to the meal cart open the entire time, and the last resident was served and eating at 12:26 p.m. At 12:27 p.m. the temperature of the meatloaf was 126 degrees Fahrenheit (F) and the temperature of the tomato soup was 123 degrees F. The meatloaf was lukewarm and not hot to taste, and the tomato soup was lukewarm, not hot to taste, and tasted sour. Interview with the Dietary Manager on April 29, 2026, at 12:43 p.m. confirmed that the food was to be palatable and was not served at the proper temperature of at least 135 degrees F. 28 Pa. Code 201.18(b)(1) Management. 28 Pa. Code 211.6(f) Dietary Services. 28 Pa. Code 211.6(b) Dietary Services.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on a review of cleaning schedules, as well as observations and staff interviews, it was determined that the facility failed to store and prepare food under sanitary conditions.Findings include:Observations in the kitchen's food prep/ tray line area on April 27, 2026, at 9:38 a.m. revealed that there were three ceiling vents that had an accumulation of dust and rust colored buildup. One ceiling tile was covered with a rust colored buildup.A review of the preventative maintenance schedule for dietary, dated 2026, revealed that there was no documented evidence that the vents or ceiling tile were cleaned or inspected until April 27, 2026.Interview with the Dietary Manager on April 27, 2026, at 9:38 a.m. confirmed that the vents needed cleaned and that maintenance was responsible for cleaning them.28 Pa. Code 211.6(f) Dietary Services.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on review of established infection control guidelines and 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 44 residents reviewed (Resident 145).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 (MDROs), dated July 12, 2022, indicates that multidrug-resistant organism (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's policy regarding EBP, dated February 27, 2026, indicated that EBP's were indicate for residents with wounds and/or indwelling medical devices regardless of MDRO colonization or infection status. Indwelling medical devices examples include central lines, urinary catheters, feeding tubes, and tracheostomies.Physician's orders for Resident 145, dated April 24, 2026, included orders for the resident to have a PICC (peripherally inserted central catheter) line and receive two grams of ampicillin intravenously every four hours.Observations of Resident 145 on April 27, 2026, at 10:45 a.m. revealed the resident was in bed and had a PICC line to his right upper arm. There was no evidence that the resident was on Enhanced Barrier Precautions or had PPE in his rom.A review of the clinical record, including physician orders, nurse's notes and current care plans, for Resident 145, revealed that there was no documented evidence that Enhanced Barrier Precautions were ordered.Interview with the Director of Nursing on April 29, 2026, at 1:25 p.m. confirmed that Enhanced Barrier Precautions were not ordered for Resident 145 at the time of admission and should have been.28 Pa. Code 211.12(d)(1)(5) Nursing services.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on review of facility policy and clinical records, as well as staff interviews, it was determined that the facility failed to develop a comprehensive care plan that included specific and individualized interventions to address the care needs for one of 44 residents reviewed (Resident 11) Findings include:The facility's policy for care planning, dated February 27, 2026, indicated that all residents will have an interim, comprehensive, and ongoing plan of care, which will be developed to outline and provide directions and interventions to provide care for the residents. It must be individualized, realistic, functional, and measurable at time frame for completion. Physician's orders for Resident 11, dated September 12, 2025, included an order for the resident to receive Humalog Injection Solution 100 unit/ml subcutaneously, according to a sliding scale three times a day (scheduled for 6:00 a.m., 12:00 p.m., 6:00 p.m.). The sliding scale included giving 0 units of insulin for a blood sugar of 70-150 milligrams/deciliter (mg/dl), 1 unit for a blood sugar of 151-199 mg/dl, 2 units for a blood sugar of 200-249 mg/dL, 3 units for a blood sugar 250-299 mg/dl, 4 units for a blood sugar of 300-349 mg/dl, 5 units for a blood sugar of 350-399 mg/dl, 5 units for a blood sugar 400-600 mg/dl and to notify the physician for further orders. However, there was no documented evidence that Resident 11's care plan included specific and individualized interventions to address care needs for his diabetes. Interview with the Director of Nursing on April 30, 2026, at 12:37 p.m. confirmed that Resident 11's care plan did not include any specific and individualized interventions to address care needs for diabetes.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	04/30/2026

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on review of policies and clinical records, as well as observations and staff interviews, it was determined that the facility failed to review and revise residents' care plans for two of 44 residents reviewed (Residents 5, 86). Findings include: The facility's policy for care planning, dated February 27, 2026, indicated that care plans will be reviewed and revised as necessary by the interdisciplinary team at least quarterly or more often as changes occur.A significant change Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 5, dated March 31, 2026, revealed that the resident was cognitively impaired and required assistance with care needs.Physician's orders for Resident 5, dated March 24, 2026, included an order for the resident to receive 100 mg of Macrobid (an antibiotic) every day for urinary tract infection with the last dose March 31, 2026. A care plan for Resident 5, dated March 30, 2026, indicated that the resident was taking an antibiotic for UTI,There was no documented evidence as of April 30, 2026 that Resident 5's care plan was revised to reflect that the resident was no longer taking an antibiotic.Interview with the Director of Nursing on April 30, at 2:26 p.m. confirmed that Resident 5's care plan was not updated to reflect the resident was no longer taking an antibiotic. An admission MDS assessment for Resident 86, dated January 21, 2026, indicated that the resident was severely cognitively impaired, had behaviors one to three days during the seven day look back period, required assistance from staff for his daily care needs, and had diagnoses that included dementia. A nursing note, dated February 19, 2026 revealed that family wishes Resident 86 to be seated a table (NOT a tray table) for meals, no yellow socks only diabetic socks, no dentures until he sees a dentist and a soft diet until further notice. A nursing note, dated March 9, 2026, revealed that the nurse aide attempted multiple times to wake Resident 86 for morning care and breakfast. Resident very agitated during attempts, was screaming vulgar words at nurse aide and threatening to hit staff. The nurse attempted multiple times to administer medication from 7:30 a.m. to 9:30 a.m., resident told the nurse to get the f*ck out of his room or he would back hand her. There was no documented evidence that Resident 86's care plan was updated to reflect his family's preferences for the resident to be out of bed for all meals, seated at the table for all meals, not to wear yellow socks, and that he should not wear dentures until he is seen by the dentist. Interview with the Director of Nursing on April 30, 2026 at 1:03 p.m. confirmed that Resident 86's care plan should have been updated to reflect his family's preferences regarding his care. 28 Pa. Code 211.12(d)(5) Nursing Services.

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Dubois Nursing Home	212 S. Eighth St. Dubois, PA 15801

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on clinical record reviews, observations, and staff interviews, it was determined that the facility failed to ensure that each resident received assistive devices to prevent accidents for one of 44 residents reviewed (Resident 75). Findings include: An admission Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 75, dated March 13, 2026, revealed that the resident was cognitively intact, used a walker, required extensive assistance from staff for care, had a history of falls, and had diagnoses that included arthritis, muscle weakness, and an abnormal gait and mobility. Physician's orders, dated March 7, 2026, included orders for the resident to transfer with one assist and a front wheeled walker. A care plan, dated April 1, 2026, revealed the resident was at risk for falls and staff were to keep the resident's call bell within reach and encourage her to use it for assistance as needed. A fall investigation, dated April 28, 2026, at 9:25 a.m. revealed the resident was found on the floor in her room after she attempted to self-transfer. She stated that she couldn't sit in her wheelchair any longer and was trying to put herself into her recliner. Observations of Resident 75 on April 30, 2026, at 10:26 a.m. revealed that the resident was in her wheelchair with leg rests on and positioned at the bottom of her bed, and her call bell was lying on the middle of the bed, out of the resident's reach. Interview with Resident 75 at that time revealed that she had been waiting for someone to put her in her recliner chair and she couldn't reach her call bell to ring for help. Interview with Nurse Aide 1 on April 30, 2026, at 10:27 a.m. confirmed that Resident 75's call bell was out of the resident's reach. Interview with the Director of Nursing on April 30, 2026, at 12:38 p.m. confirmed that Resident 75's call bell should have been in the resident's reach. 28 Pa. Code 211.10(c)(d) Resident care policies. 28 Pa. Code 211.12(d)(3)(5) Nursing services.

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Dubois Nursing Home	212 S. Eighth St. Dubois, PA 15801

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. Based on review of policies and clinical records, as well as staff interviews, it was determined that the facility failed to change an indwelling urinary catheter as ordered by the physician for one of 44 residents reviewed (Resident 137).Findings include:The facility policy for urinary catheter care, dated February 27, 2026, indicated that changing indwelling catheters or drainage bags at routine, fixed intervals, was not recommended. Rather it was suggested to change catheters and drainage bags based on clinical indications such as infection, obstruction, or when the closed system was compromised.An admission Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 137, dated February 17, 2026, revealed that the resident was cognitively intact, was dependent on staff for her daily care needs, had an indwelling urinary catheter, and had diagnoses that included neurogenic bladder (a lack of bladder control due to a brain, spinal cord, or nerve condition) and a urinary tract infection. Physician's orders for Resident 137, dated February 12, 2026, included an order for the resident to have an indwelling urinary catheter and it was to be changed every month. A care plan, dated February 12, 2026, revealed that the catheter was to be changed as ordered.Treatment Administration Records (TAR's) for March 2026 revealed that Resident 137's urinary catheter was not changed on March 12, 2026, as ordered.Interview with the Director of Nursing on April 30, 2026, at 2:52 p.m. confirmed that there was no documented evidence that Resident 137's urinary catheter was changed during March 2026.28 Pa. Code 211.12(d)(3)(5) Nursing services.

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F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results. Based on review of policies and clinical records, as well as staff interviews, it was determined that the facility failed to notify the physician of laboratory test results for one of 44 residents reviewed (Resident 123).Findings include: The facility policy for laboratory tests, dated February 27, 2016, indicated that the physician would be notified immediately if a test was obtained to monitor the blood level of a medication and the level was reported as high (above therapeutic range) or toxic, the nurse will notify the physician promptly and will not give the next dose until the situation has been reviewed with the physician.An admission Minimum Data Set (MDS) assessment (a mandated assessment of a resident's care needs and abilities) for Resident 123, dated February 24, 2026, revealed the resident was cognitively impaired, received anticoagulant medication (used to thin blood), and had a diagnosis of heart failure. The resident's care plan, dated March 3, 2026, indicated that he was at risk for bleeding due to anticoagulant therapy, and ordered labs were to be scheduled, results reviewed, and the results reported to the physician.Physician's orders for Resident 123, dated March 12, 2026, included an order for the resident to receive 7.0 milligrams (mg) of Coumadin (medication that thins the blood) at bedtime due to a prosthetic heart valve. The resident was also ordered to have blood drawn for prothrombin time and international normalized ratio (PT/INR - blood tests that determine how long it takes the blood to clot) to monitor the therapeutic levels (appropriate range) of Coumadin to be completed on March 19, 2026. A review of the clinical records for Resident 123, including nursing notes and a laboratory report, dated March 19, 2026, revealed no documented evidence that the physician was notified of Resident 123's PT/INR results. Interview with the Director of Nursing on April 30, 2026, at 12:38 p.m. confirmed that the physician was not notified of the results of the PT/INR obtained on March 19, 2026. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing Services.