STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395446	A. Building B. Wing	05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Towne Manor East	2004 Old Arch Road Norristown, PA 19401

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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46508 Based on review of facility security camera footage, clinical record reviews, review facility policy, review of facility documents and staff interviews, it was determined that the facility failed to ensure that one of one resident reviewed was free from physical restraints (Resident R1) Findings include: Review facility policy on Restraint Management revealed that the facility will promote quality of life and resident centered care. Restraints will be used only when necessary to treat a medical symptom and not used for staff convenience. The least restrictive restraint for the shortest duration of time will be applied to assist the resident in reaching their highest level of physical and psychological well-being. The facility will document and demonstrate the presence of specific medical symptoms that requires the use of the restraint to treat the cause of symptoms. The interdisciplinary team will assess medical symptoms by evaluating resident's condition, circumstances, and environment. The facility recognizes that a physical restraint may be required when resident's medical symptoms lead to behaviors that threaten the safety or the safety of others, restraint alternatives are determined to be ineffective, a resident has medical conditions that may benefit from short term use of physical restraints. Physical restraint is defined as any manual method of physical or mechanical device, material or equipment attached or adjacent to the residence body that the individual cannot remove easily, which restricts freedom of movement or normal access to one's body. Manual method means to hold or limit a residence voluntary movement by using body contact as a method of physical restraint. Psychological impact related to the use of physical restraints might include one or more of the following: a. agitation, aggression, anxiety, or development of delirium. b. Loss of dignity, self-respect, and identity. c. Dehumanization. d. Panic, feeling threatened or fearful, e. feeling of imprisonment or restriction of freedom of movement. f. Feeling of shame. Review of Resident R1's clinical record revealed that Resident R1 was admitted to the facility on [DATE], with diagnoses of Anoxic Brain Damage (a damage in the brain caused by lack of oxygen), Vascular Dementia, Lack of Coordination, Unsteadiness on Feet, Anxiety Disorder. Review of Resident R1's admission Minimum data Set (MDS- assessment of resident care needs) dated April 19, 2024, section C0500 BIMS (Brief interview for mental status) score revealed that resident scored 6 suggesting severe cognitive impairment. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of facility investigation and statement from Licensed nurse, Employee E3 on an incident between Resident R1 and Licensed nurse, Employee E3 revealed that on May 4, 2024, at 6:45 p.m., Resident R1 wanted to go out to smoke but that Resident R12 was not a smoker and resident was re-directed by Licensed nurse, Employee E3. Further Licensed nurse, Employee E3 revealed in his statement that resident got very close to him, and that resident started to swing at him. Employee R3 further revealed that he then grabbed Resident R1 and pushed him to the floor and told resident to calm down. Two other nurse's aides helped Resident R1 off the floor. Review of statement from Nurse aide, Employee E5 dated May 4, 2024, revealed that Employee E5 saw Licensed nurse, Employee E3 stumble and fall on top of Resident R1, Employee E3 was trying to calm Resident R1 and trying to prevent Resident R1 from hitting Employee E3. Licensed nurse, Employee E3 then got up and Nurse aide, Employee E5 assisted Resident R1 from the floor. Review of Nurse aide, Employee E6's statement revealed that Resident R1 wanted to smoke. Licensed nurse, Employee E3 redirected Resident R1 to his room and Resident R1 became very verbally and physically aggressive towards Licensed nurse, Employee E3. Then Licensed nurse, Employee E3 stumbled over Resident R1 while trying to prevent Resident R1 from attacking him. Review of facility security camera footage (without audio) conducted on May 17, 2024, at 10:35 am with Nursing Home Administrator, Employee E1, Director of Nursing, Employee E2 and Director of Maintenance, Employee E4 revealed a footage from security camera dated May 4, 2024, which showed Resident R1 on the hallway in the vicinity of the unit exit. Licensed nurse, Employee E3 then walked towards Resident R1. Licensed nurse, Employee E3 and Resident R1 appeared to be having a discussion. Licensed nurse, Employee E3 walked away towards the inside of the unit and Resident R1 then proceeded to walk towards the same direction, Licensed nurse, Employee E3 then stopped and Resident R1 was standing close to the wall and close to Licensed nurse, Employee E3. Employee E3 then grabbed Resident R1's right arm with his left hand, Resident R1 appeared to attempt to free himself from Employee E3's grasp, Employee E3 then grabbed Resident R1's left arm with Employee E3's right hand right hand and held Resident R1 against the wall. Resident R1 started to struggle and Resident R1 proceeded to attempt to place Employee E3 on a head lock. Resident R1 and Employee E3 then fell to the floor with Employee E3 on top of Resident R1. Employee E3 then restraint both of Resident R1's arms on the floor while Employee E3 was at the same time straddling the resident. Two female employees were observed coming toward Licensed nurse E3 and Resident R1. Employee E3 then released his grip from Resident R1 and the two female employee's assisted Resident R1 off the floor. 28 Pa. Code 211.8(a) Use of restraints 28 Pa. Code 211.12(d)(1) Nursing services 28 Pa. Code 211.12(d)(3)(5) Nursing services

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F 0741 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that the facility has sufficient staff members who possess the competencies and skills to meet the behavioral health needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46508 Based on observation, review of facility documents and interview with staff, it was determined that the facility failed to ensure that a resident who exhibited behavior problems was provided with appropriate behavioral management to de-escalate the inappropriate behavior (Resident R1). Findings include: Review of Resident R1's clinical record revealed that Resident R1 was admitted to the facility on [DATE], with diagnoses of Anoxic Brain Damage (a damage in the brain caused by lack of oxygen), Vascular Dementia, Lack of Coordination, Unsteadiness on Feet, Anxiety Disorder. Review of Resident R1's admission Minimal Data Set (MDS- assessment of care needs) dated April 19, 2024, section C0500 BIMS (Brief interview for mental status) score revealed that resident scored 06 suggesting severe cognitive impairment. Review facility training materials on Preventing and Managing Catastrophic Reactions revealed that Catastrophic Reaction is defined as emotional outbursts, sometimes accompanied by physical-action behavior that seems inappropriate or out of proportion to the situation. This reaction may be triggered by a present event or by one from the distant past. Under section Preventing and managing catastrophic reactions. #1 Excessive response-People with brain damage are easily overwhelmed and may respond with excessive emotions and behaviors as a result of frustration, cognitive overload, or the inability to communicate needs or perform tasks. #2. Caregivers and wittingly precipitate this reaction in people with dementia due to a lack of understanding of the causes of Catastrophic Reaction #B. Lack of communication. #C. The result of a power struggle that leaves the resident and caregiver feeling frustrated. #3, physical violence nearly always occurs if someone initiates physical contact while the resident is suffering from a catastrophic reaction. Under section What to do to avoid a catastrophic reaction #1. Prevention is always better than the cure. Avoid: #e. Arguing with resident to make them see your view. #f. Communicating in a way that asserts authority or lack of respect. Under section Specific management strategies for catastrophic reactions. #5 Eliminate distractions. #6. prevent escalation by backing off. #7. Personal space. #8. Observe residents body language and validate the emotions that they are feeling. #9 Set signals that all staff are aware of which are to be used if other strategies fail and you need help. Under section Specific communication strategies for catastrophic reactions. #2. Use positive nonverbal communication. #7. Only use touch to guide and reassure and only if it has positive effect. Under Section facility emergency interventions for catastrophic reactions. #1. If preventative steps do not work, call for help, announce code cat and location. Review of educational in-service packet for Licensed nurse, Employee E3 revealed that Employee E3's most recent staff education was on January 20, 2023 with the following topics: Serious reportable events, Abuse/neglect/exploitation, Abuse/Neglect/Elder Justice Act, Dementia and behavior management, Behaviors and psychotropic, Advanced Directives, Infection control, Ethics and compliance, and Trauma informed car. (continued on next page)

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F 0741 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with Staff Development Coordinator, Employee E7 Revealed that the facility provided l staff training on Behavior Management and De-escalation of behavior during orientation and annually and that the facility also have code cat- (catastrophic reaction) for resident behaviors, altercations between resident-to-resident or resident-to-staff. When needed staff will call the code and location, alerts the staff to the situation- all hands-on deck. Further Employee E7 revealed that all staff are trained on how to respond to the code and that drills are done. The facility also provide training on Preventing and Managing Catastrophic Reactions to manage resident behaviors. Staff Development Coordinator, Employee E7 confirmed the above training was not applied during the incident and that the incident was not properly de-escalated according to the training. Further, Staff Development Coordinator, Employee E7 also confirmed that Licensed staff, Employee E3's most recent annual in-service training on Behavior Management and De-escalation of behavior Preventing and Managing Catastrophic Reactions to manage resident behaviors was conducted in January 2023. Further Employee 7 also confirmed that Employee E3 in- service should have been completed by January 2024. 28 Pa. Code 201.20(a) Staff development 28 Pa Code 201.20(C) Staff development 28 Pa. Code 211.12(d)(3) Nursing services