| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 395460 | A. Building<br>B. Wing | 06/04/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Christ the King Manor | 1100 West Long Avenue<br>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 0760<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure that residents are free from significant medication errors.<br><br>Based on a review of facility policies and clinical records, as well as staff interviews, it was determined that the facility failed to ensure that physician's orders were followed, resulting in significant medication errors for one of 35 residents reviewed (Resident 93).Findings include:A Quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 93, dated June 2, 2026, revealed that the resident was cognitively intact, received an anticoagulant (blood thinner), and had diagnoses that included cerebral infarction (a loss of blood flow to the brain causing physical deficits). Physician's orders for Resident 93, dated December 18, 2026, included an order for the resident to receive 3.5 milligrams (mg) of warfarin (blood thinning medication) daily for a mechanical heart valve (surgically implanted artificial valve that require lifelong blood-thinning medication). A review of Resident 93's Medication Administration Record (MAR) for December 2025, revealed that the resident did not receive any warfarin from December 18 through December 21, 2025. Physician's orders for Resident 93, dated May 12, 2026, included an order for the resident to receive 4 mg of warfarin on May 12, 2026, 3.5 mg of warfarin on May 13, 2026, 4mg of warfarin on May 14, 2026, and 3.5mg warfarin on May 15, 2026. A review of Resident 93's MAR, dated May 2026 revealed that staff administered 7.5 mg of warfarin on May 12, 2026, no warfarin on May 13, 2026, 7.5mg warfarin on May 14, 2026, and no warfarin on May 13, 2026, or May 15, 2026. Interview with the Director of Nursing on June 4, 2026, at 1:08 p.m. confirmed that a medication error occurred in December and the resident did not receive the warfarin as ordered and that the physician's orders for warfarin were not followed in May 2026. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing Services. |

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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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>Based on clinical record reviews and staff interviews, it was determined that the facility failed to review and revise care plans for two of 35 residents reviewed (Residents 12, 14). Findings include:An admission Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 12, dated April 7, 2026, indicated that the resident had moderate cognitive impairment, required assistance from staff for her daily care needs and had diagnoses that included diaphragmatic hernia with obstruction (a defect in the diaphragm, which is the muscle separating the chest from the abdomen, that allows abdominal organs to push into the chest cavity and become trapped, twisted, or blocked, preventing the normal passage of food). Physician's orders for Resident 12, dated April 3, 2026, included an order for the resident to receive a full liquid diet with thin consistency liquids. A care plan for Resident 12, dated April 3, 2026, indicated that the Resident had anemia (low levels of healthy red blood cells), and a large hiatal hernia with food impaction (food is lodged, or trapped in a body cavity or passage). The resident was to be encouraged to eat food rich in iron such as green leafy vegetables, meat, eggs, poultry, nuts, grains, cereal and dried beans. A care plan for Resident 12 dated April 7, 2026, indicated that the Resident had the potential for altered nutrient utilization because of a large hiatal hernia with mechanical impaction. Staff were to provide and serve a full liquid diet. Interview with the Nursing Home Administrator on June 4, 2026, at 2:33 p.m. confirmed that Resident 12's care plan did not accurately reflect the resident's active care needs and should have been revised. A Quarterly MDS assessment for Resident 14, dated May 2, 2026, indicated that the resident was cognitively impaired and required assistance from staff for daily care needs. The resident's care plan, dated May 5, 2026, indicated that the resident had behaviors.A nursing note for Resident 14, dated May 3, 2026, indicated that the resident stated he wanted to harm himself.Interview with Nurse Aide 1 on June 2, 2026, at 2:05 p.m. revealed that Resident 14 makes self-harm threats when he gets frustrated and has made similar statements in the past.There was no documented evidence that Resident 14's care plan was updated to reflect his statements of self-harm or what interventions the staff should use when he makes these statements.Interview with the Director of Nursing on June 4, 2026, and 2:28 p.m. confirmed that Resident 14's care plan should have been updated to reflect his statements of self-harm.28 Pa. Code 211.11(d) Resident care plan.28 Pa. Code 211.12(d)(5) Nursing services. |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident?s preferences and goals.<br><br>Based on facility policy and clinical record reviews, as well as staff interviews, it was determined that the facility failed to follow physician's orders for one of 35 residents reviewed (Resident 12). Findings include:A facility policy for administration of medications dated January 4, 2026, included that it is the responsibility of the nursing professional to be aware of classifications, action, correct dosage and side effects of medication before administration. An admission Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 12, dated April 7, 2026, indicated that the resident had moderate cognitive impairment, required assistance from staff for her daily care needs and had diagnoses that included diaphragmatic hernia with obstruction (a defect in the diaphragm, which is the muscle separating the chest from the abdomen, that allows abdominal organs to push into the chest cavity and become trapped, twisted, or blocked, preventing the normal passage of food). Physician's orders for Resident 12 dated April 3, 2026, included an order for the resident to receive 0.5 milligrams (mg) of lorazepam (federally regulated controlled drug used to treat anxiety) one tablet by mouth in the morning for anxiety, one-half tablet by mouth at bedtime for anxiety. Physician's orders dated April 3, 2026, also included an order for the resident to receive 0.5 mg of lorazepam one-half tablet by mouth as needed for anxiety/restlessness for 14 days. Review of the controlled drug record (a form that accounts for each tablet/pill/dose of a controlled drug) sheet dated April 5, 2026, revealed that on April 6, 2026, at 8:20 p.m. one tablet of 0.5 mg of lorazepam was signed out to be administered for the bedtime dose. There was no documented evidence that that one half of the tablet was administered and one half of the tablet was wasted. Review of the controlled drug record sheet dated April, 2026, revealed that on April 7, 2026, at 12:00 a.m. one tablet of 0.5 mg of lorazepam was signed out to be administered. Review of the Medication Administration Record (MAR) dated April 2026 revealed that one-half tablet was to be administered. There was no documented evidence that that one half of the tablet was administered and one half of the tablet was wasted.Review of the controlled drug record sheet dated May, 2026, revealed that on May 22, 2026, one tablet of 0.5 mg of lorazepam was signed out to be administered for the bedtime dose. There was no documented evidence that that one half of the tablet was administered and one half of the tablet was wasted.Interview with Director of Nursing on June 4, 2026, at 3:56 p.m. confirmed that one tablet of 0.5mg was signed out on the controlled drug record to be administered when one-half tab was to be administered on the above mentioned dates and times, and there was no documented evidence that that one half of the tablet was administered and one half of the tablet was wasted.28 Pa. Code 211.12(d)(1)(3)(5) Nursing Services. |