STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395480	A. Building B. Wing	04/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mahoning Valley Nursing and Re	397 Hemlock Drive Lehighton, PA 18235

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26142 Based on observation, a review of clinical records and facility investigative reports, resident and staff interview it was determined the facility failed to consistently provide care and services consistent with professional standards of practice, to prevent the development of pressure ulcers for one resident out of 10 sampled residents. (Resident 1) Findings: According to the US Department of Health and Human Services, Agency for Healthcare Research & Quality, the pressure ulcer best practice bundle incorporates three critical components in preventing pressure ulcers: Comprehensive skin assessment, Standardized pressure ulcer risk assessment and care planning and implementation to address the areas of risk. The American College of Physicians (ACP) is a national organization of internists, who specialize in the diagnosis, treatment, and care of adults. The largest medical-specialty organization and second-largest physician group in the United States) Clinical Practice Guidelines indicate that the treatment of pressure ulcers should involve multiple tactics aimed at alleviating the conditions contributing to ulcer development (i. e. support surfaces, repositioning and nutritional support); protecting the wound from contamination and creating and maintaining a clean wound environment; promoting tissue healing via local wound applications, debridement and wound cleansing; using adjunctive therapies; and considering possible surgical repair. A review of Resident 1's clinical record revealed the resident was admitted to the facility on [DATE], with diagnoses including dementia, respiratory failure, and a history of falling at home. Resident 1 was discharged home on March 13, 2025. A review of a quarterly Minimum Data Set assessment (MDS - a federally mandated standardized assessment process conducted periodically to plan resident care) dated February 5, 2025, indicated the resident was moderately impaired with a BIMS score of 3(brief interview for mental status, a tool to assess the residents attention, orientation and ability to register and recall new information, a score of 00-07 equates to severe cognitive impairment). The MDS further identified the resident as requiring staff assistance for activities of daily living (ADLs) and at risk for pressure ulcer development. (continued on next page)

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 1's care plan-initiated January 29, 2025, identified the resident as being at risk for impaired skin integrity related to aspirin therapy (a medication with anticoagulant, bleeding, properties), which made the resident prone to bruising with slight pressure, decreased mobility, history of falls, and incontinence. Interventions included assessing skin integrity for changes (noting color, texture, temperature, redness,) keeping the skin clean and dry, applying protective creams or lotions, preventing friction, and toileting the resident after meals. An additional care plan problem identified on January 29, 2025, indicated the resident experienced decreased ADL performance due to muscle wasting and atrophy (breakdown of body tissue). Interventions included the use of a mechanical lift for all transfers and assistance of two staff for toileting. A review of facility investigative documentation dated February 16, 2025, at 3:00 AM, revealed that Employee 3 (RN) was called to Resident 1's room by nurse aide staff to assess a new open area on Resident 1's left inner gluteal fold. Upon assessment the area measured 1.5 cm x 0.5 cm x 0.1 cm, with red granulation tissue and minimal serosanguinous drainage (combination or blood and fluid). The physician was called, and a treatment was ordered. The report noted that the resident was resistive when staff tries to reposition him on his side. Documentation indicated the resident was resistant to repositioning, utilized a mechanical lift for transfers, was confused, and was incontinent of urine at the time of discovery. Witness statements dated February 16, 2025, at 3:00 AM from Employees 1 and 2 (Nurse Aides) confirmed they observed the area during care on February 16, 2025, and reported it to the nurse. A subsequent facility investigative report dated February 16, 2025, at 9:30 AM, revealed that Employee 4 (Nurse Aide) observed additional open and discolored areas on the resident's buttocks and sacrum during care. Employee 6 (RN) assessed the areas, which included: Sacrum: open area measuring 1 cm x 1 cm, no drainage. Left buttock: open area measuring 1.5 cm x 1.5 cm with surrounding dark purple, non-blanchable skin measuring 7 cm x 3.5 cm. Left outer buttock: open area measuring 3 cm x 1 cm with surrounding dark purple, non-blanchable skin. Left upper outer buttock: intact, non-blanchable purple area measuring 1 cm x 0.5 cm. The physician was notified of these additional areas. Witness statements from Employee 5 indicated that the resident was last observed at 8:00 AM on February 16, 2025, lying in bed. A physician's order dated February 17, 2025, directed the use of an alternating air mattress and Juven nutritional supplement (used to promote wound healing). Weekly wound assessments documented the progression of wound status as follows: February 21, 2025 (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Sacrum: 1 cm x 1 cm x 0.1 cm, deep tissue injury (DTI) (damage beneath intact skin, typically presenting as a dark purple area). clean the area with normal saline and apply silver alginate (protect the wound from external contaminants, maintain a moist environment conducive to healing, and help manage exudate, drainage) and cover with a foam dressing every shift and as needed. Left buttock: 4 cm x 3 cm x 0.1 cm, DTI. with scant serosanguinous drainage Right buttock: 5 cm x 3 cm x 0.1 cm, DTI. the peri wound noted as deep purple in color with scant serosanguinous drainage. Treatments included cleansing with normal saline and applying silver alginate dressings (used to manage exudate and support healing), covered with foam dressings. February 28, 2025 Sacral wound resolved. Left and right buttocks: unstageable pressure injuries (wounds obscured by slough - soft, yellow dead tissue - or eschar - hard, black dead tissue). The left buttock measured 4 cm x 3 cm x 0.1 cm, and the right buttock measured 5 cm x 3 cm x 0.1 cm Wounds contained 20% granulation tissue and 80% slough. Treatment changed to cleanse with normal saline and wet-to-dry dressings (used to assist with gentle debridement). March 7, 2025 Wounds remained unstageable with the same measurements and tissue composition. Treatment regimen unchanged. A review of a nurses note dated March 10, 2025, at 12:25 PM revealed, described the resident being combative during care, striking staff. The eschar from one wound was dislodged, revealing 1 cm depth and red granulation tissue. Minor drainage was noted. The resident's wife was informed at the time of observation. A review of a nurses note dated March 12, 2025, at 11:58 AM documented providing the resident's wife with education about the wounds to the resident's buttocks and provided treatment supplies. The resident's wife verbally acknowledged understanding the wound condition and treatment needs. A review of interdisciplinary discharge instructions dated March 13, 2025, revealed wound care treatment instructions. However, no measurements or detailed descriptions of the wounds were documented as being provided to the resident's wife prior to discharge An interview with the Director of Nursing (DON) and Nursing Home Administrator (NHA) on April 10, 2025, at approximately 1:00 PM, confirmed the facility failed to implement timely and adequate preventive measures necessary to prevent the development of pressure ulcers to the sacrum and buttocks for Resident 1. 28 Pa. Code: 211.12 (d)(1)(3)(5) Nursing Services