

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395480	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/22/2024
NAME OF PROVIDER OR SUPPLIER Mahoning Valley Nursing and Re		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>48276</p> <p>Based on the review of the facility's abuse prohibition policy, clinical records, select facility investigations, and staff interviews, it was determined that the facility failed to timely report resident physical abuse to the State Survey Agency for one of the 20 residents reviewed (Resident 5).</p> <p>Findings include:</p> <p>A review of the facility's Prevention of Abuse/Neglect/Involuntary Seclusion/Exploitation: The Facility Procedures Policy, last reviewed by the facility in October 2023, revealed that the facility's policy is for staff to report any allegations of abuse, neglect, misappropriation of property, exploitation, or involuntary seclusion to their supervisor immediately. The facility administrator or designee will be responsible for the follow-up investigation and reporting to the required agencies within the required time frames. The policy indicated that the investigation results will be reported to the State Survey Agency and all other required agencies within five days of the allegation.</p> <p>Facility investigation documents dated February 29, 2024, indicated that a nurse aide observed Resident 4 use the back of her hand to hit Resident 5 in the mouth.</p> <p>A Resident Incident Investigation form dated February 29, 2024, revealed that Employee 2, a Nurse Aide, observed Resident 4 in the hallway telling Resident 5 to shut up and was holding her {Resident 5's} left wrist. {Resident 4} let go of Resident 5's wrist and slapped {Resident 5} with the backside of her hand across {Resident 5's} mouth. The residents were separated, and the incident was reported to supervisory staff.</p> <p>A progress note dated February 29, 2024, at 5:25 PM indicated that {Resident 4} hit her roommate with the back of her hand. Resident 4 stated that she wouldn't knock it off! I want her to shut up!</p> <p>A progress note dated February 29, 2024, at 5:25 PM indicated that Resident 5 was unable to describe details of the interaction but indicated to staff that I'm okay. Resident 5 was assessed with no skin impairments, open areas, bruising, swelling, or dental issues.</p> <p>During an interview on March 21, 2024, at approximately 1:00 PM, the Nursing Home Administrator (NHA) and Director of Nursing (DON) confirmed that the facility failed to report physical abuse of Resident 5 perpetrated by Resident 4 to State Survey Agency within the required time frames.</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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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	28 Pa Code 201.14 (c) Responsibility of licensee 28 Pa Code 201.18 (e)(1) Management

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<p>F 0623</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21738</p> <p>Based on clinical record reviews and staff interview, it was determined that the facility failed to ensure that a written notice of facility-initiated transfer to the hospital was provided to the resident and resident's representative for four residents out of 20 residents sampled (Residents 47, 8, 18 and 39).</p> <p>Findings include:</p> <p>A review of Resident 47's clinical record revealed that the resident was transferred to the hospital on August 28, 2023, and returned to the facility on [DATE].</p> <p>A review of Resident 8's clinical record revealed that the resident was transferred to the hospital on December 14, 2023, and returned to the facility on [DATE]. The resident was transferred to the hospital on December 22, 2023, and returned to the facility on [DATE] and transferred again on January 5, 2024, and returned to the facility on [DATE].</p> <p>A review of Resident 18's clinical record revealed that the resident was transferred to the hospital on September 9, 2023, and returned to the facility on [DATE].</p> <p>A review of Resident 39's clinical record revealed that the resident was transferred to the hospital on February 21, 2024, and readmitted to the facility on [DATE].</p> <p>Clinical record reviews of the above residents revealed no evidence written notices had been provided to these residents and their representatives regarding the transfer that included all required contents: reason for the transfer, effective date of the transfer, location to which the resident was transferred, contact and address information for the Office of the State Long-Term Care Ombudsman, and, if applicable, information for the agency responsible for the protection and advocacy of individuals with developmental disabilities.</p> <p>Interview with the Nursing Home Administrator on March 21, 2024, at 11:10 AM confirmed that there was no evidence that a written notification of transfer which contained all required contents was provided to residents and the residents' representatives for these facility initiated transfers.</p> <p>28 Pa. Code 201.29 (c.3)(2) Resident rights</p> <p>28 Pa. Code 201.14 (a) Responsibility of Licensee</p>		

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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>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48277</p> <p>Based on clinical record review and staff interview it was determined that the facility failed to develop a comprehensive person-centered plan of care to meet the individualized needs of one resident out 20 sampled (Resident 19).</p> <p>Findings include:</p> <p>Review of Resident 19's clinical record revealed that the resident was admitted to the facility on [DATE], with diagnoses to include heart failure (a condition in which the heart fails to sufficiently pump blood throughout the body) and the presence of an automatic implantable cardiac defibrillator (AICD- is a microcomputer that is implanted under the skin of the upper chest area. It monitors heart rate and delivers therapy in the form of small electrical pulses. An AICD is a permanent device inserted into the right ventricle and typically placed near the collarbone under the skin of the chest).</p> <p>A review of a cardiology progress note dated January 26, 2024, revealed that the resident had a single AICD implanted for heart failure. The cardiologist indicated that the resident was seen due to a planned move to the skilled nursing facility. He further indicated that a note was sent to the facility to ensure that the move does not affect his AICD device.</p> <p>A review of the resident's current comprehensive care plan, conducted during the survey ending March 22, 2024, indicated that the facility identified a problem area of Resident 19's diagnosis of coronary artery disease (damage or disease in the heart's major blood vessels) due to hypertension, atrial fibrillation, AICD, and ischemic cardiomyopathy. However, the resident's care plan did not include AICD checks or monitoring for signs and symptoms of AICD complications.</p> <p>The resident's care plan did not include any emergency care of the AICD device and actions to be taken if the AICD was activated (i.e., consulting the physician, obtaining vital signs [clinical measurements, specifically pulse rate, temperature, respiration rate, and blood pressure, that indicate the state of a patient's essential body functions] and keeping the resident and staff safe from the electrical shock. The resident should notify staff if a shock is felt, and staff should be aware not to touch resident is being shocked since the shock can be felt).</p> <p>Interview with Employee 1 (RN, MDS Coordinator) on March 20, 2024, at 2:16 PM confirmed that the facility failed to fully address the care and management of Resident 19's AICD on the resident's person-centered plan of care.</p> <p>28 Pa. Code 211.12 (c)(d)(3)(5) Nursing services.</p>		

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<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide safe, appropriate pain management for a resident who requires such services.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41581</p> <p>Based on a review of clinical records and select facility policy and resident and staff interviews, it was determined that the facility failed to provide person-centered pain management consistent with professional standards of practice for two out of the 20 residents sampled (Residents 8 and 43).</p> <p>Findings include:</p> <p>A clinical record review revealed Resident 43 was admitted to the facility on [DATE], with diagnoses that included cervical and intervertebral disc disorders (conditions characterized by the breakdown of one or more of the discs that separate the bones of the spine and neck, causing pain in the back, neck, or frequently in the legs and arms).</p> <p>A review of a quarterly Minimum Data Set assessment (MDS - a federally mandated standardized assessment process conducted periodically to plan resident care) dated February 16, 2024 revealed that Resident 43 is cognitively intact with a BIMS score of 13 (Brief Interview for Mental Status- a tool within the Cognitive Section of the MDS that is used to assess the resident's attention, orientation, and ability to register and recall new information; a score of 13-15 indicates cognition is intact). The MDS Section J-Health Conditions indicated that the resident almost constantly experiences pain or was hurting.</p> <p>Resident 43's care plan noted the resident's potential for pain related to his disc disorders, which was initiated on November 10, 2023. Interventions developed to assist the resident with his pain included monitoring, recording, and reporting complaints of pain or requests for pain treatment, evaluating the effectiveness of pain treatment, and offering and encouraging non-pharmacological pain relieving methods such as repositioning, back rubs, soothing or distraction activity, guided imagery, breathing exercises, offering pillows or blankets, bathing, or elevation.</p> <p>A physician's order was initiated on November 9, 2023, for Resident 43 to receive oxycodone HCL oral tablet 5 mg (an opioid medication) with instructions to give 1 tablet every 6 hours as needed for moderate to severe pain.</p> <p>The resident's medication administration record (MAR) for March 2024 revealed that Resident 43 received oxycodone 5 mg on 22 occasions from March 1, 2024, through March 21, 2024.</p> <p>There was no evidence that staff attempted any non-pharmacological attempts to relieve Resident 43's pain prior to administering as-needed opioid medication.</p> <p>There was no documented evidence that the facility had consistently assessed Resident 43's level of pain to ensure that the opioid medication was administered as per physician's orders, for moderate to severe pain.</p> <p>A review of progress note documentation and Resident 43's MAR for March 2024 revealed that the resident received oxycodone 5 mg on 18 occasions without documentation of the resident's pain level prior to administration of the medication.</p> <p>(continued on next page)</p>		

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<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on March 19, 2024, at 10:10 AM, Resident 43 stated that he experiences consistent back pain. The resident explained that the facility provides a medicated ointment and pain medication that helps with the pain but further stated that the facility is not offering alternative non-pharmacological interventions to assist with his pain relief.</p> <p>During an interview on March 22, 2024, at approximately 10:00 AM, the Director of Nursing (DON) and Nursing Home Administrator (NHA) were unable to provide evidence that the facility consistently attempted non-pharmacological interventions prior to pain medications prescribed on an as needed basis. The NHA and DON were not able to provide evidence that the facility was consistently assessing the resident's pain levels prior to medication administration to ensure medications were being administered consistent with physician's orders.</p> <p>A review of the clinical record revealed that Resident 8 was admitted to the facility on [DATE], with diagnoses to include pyogenic arthritis, and spondylosis (degenerative arthritis of the spine).</p> <p>A review of Resident 8's physician order's initially dated January 11, 2024, revealed an order for oxycodone (a narcotic opioid pain medication) 5 mg tablet, give two tablets by mouth, every four hours, as needed, for severe pain.</p> <p>A review of the resident's February 2024 Medication Administration Record (MAR) revealed that staff administered the pain medication 48 times during the month of February. Of the 48 doses given, all were administered without non-pharmacological interventions attempted prior to giving the pain medication.</p> <p>A review of the resident's March 2024 Medication Administration Record (MAR) revealed that staff administered the pain medication 12 times during the month of March Of the 12 doses given, 11 were administered with no non-pharmacological interventions attempted prior to giving the pain medication.</p> <p>Interview with the Director of Nursing on March 22, 2024, at approximately 1:30 PM confirmed that there was no evidence that non-pharmacological interventions were consistently attempted and proved ineffective prior to administration of as needed pain medication.</p> <p>28 Pa. Code 211.12 (c)(d)(1)(5) Nursing Services</p> <p>28 Pa. Code 211.5 (f) Medical records</p>		

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<p>F 0744</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48276</p> <p>Based on a review of clinical records and staff interviews, it was determined that the facility failed to develop and implement individualized plans to manage residents' dementia related behavioral symptoms to promote resident safety and the residents' highest practicable physical and mental well-being for one resident out of 20 sampled (Resident 4).</p> <p>Findings include:</p> <p>A clinical record review revealed that Resident 4 was admitted to the facility on [DATE], with diagnoses that included Alzheimer's disease (a brain disorder that slowly destroys memory and thinking skills and, eventually, the ability to carry out the simplest tasks).</p> <p>A review of an annual Minimum Data Set assessment (MDS - a federally mandated standardized assessment process conducted periodically to plan resident care) dated February 2, 2024 revealed that Resident 4 has severe cognitive impairment with a BIMS score of 02 (Brief Interview for Mental Status- a tool within the Cognitive Section of the MDS that is used to assess the resident's attention, orientation, and ability to register and recall new information; a score of 00-07 indicates severe cognitive impairment).</p> <p>Nursing progress notes dated January 10, 2024, at 11:25 AM that indicated that Resident 4 was having increased behaviors that morning, incessantly calling out different things at staff, yelling for help, and yelling for different people.</p> <p>A progress note dated January 13, 2024, at 4:46 AM indicated that the resident was calling out and yelling, Get me the hell out of here!</p> <p>On January 23, 2024, at 4:30 PM progress notes indicated that the resident was consistently yelling out help, entering other residents rooms, arguing with other residents, and stating, I am going to throw myself to the floor.</p> <p>Nursing noted January 24, 2024, at 12:38 PM that the resident was agitated during a shower. The note indicated that the resident was swinging a shower head and attempting to bite and kick staff.</p> <p>On February 16, 2024, at 12:34 AM, nursing noted that the resident was calling out continually, Help! Help! Who the hell am I? Does anybody know me?</p> <p>Nursing progress notes dated February 28, 2024, at 10:43 PM indicated that the resident was agitated and restless throughout the shift, wheeling herself into other residents' rooms, yelling, and pulling apart her oxygen tubing and on February 29, 2024, at 5:25 PM the resident hit her roommate with the back of her hand. Resident 4 stated that she wouldn't knock it off! I want her to shut up!</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 - Few</p>	<p>Nursing documentation dated 2, 2024, at 1:57 AM indicated that the resident was screaming and yelling throughout the shift; on March 7, 2024, at 10:30 PM it was noted that the resident was entering other residents rooms, yelling at other residents, and attempting to open locked doors like the maintenance closet; and on March 15, 2024, at 3:50 AM it was documented that the resident was continually calling out and disrupting other residents.</p> <p>A review of Resident 4's care plan, conducted during the survey ending March 22, 2024, revealed that the resident's plan of care did not include the resident's behaviors, such hitting, biting, yelling out, screaming, and entering other residents' rooms.</p> <p>The facility failed to demonstrate the provision of necessary care and services, including individualized interdisciplinary non-pharmacological approaches to care, purposeful and meaningful activities, that address the resident's customary routines, interests, preferences, and choices to enhance the resident's well-being. There was no evidence that the facility provided the resident with specialized services and supports, such specialized activities, nutrition, and environmental modifications, based on the individual's abilities and dementia related behaviors.</p> <p>During an interview on March 21, 2024, at approximately 1:10 PM, the Nursing Home Administrator (NHA) and Director of Nursing (DON) confirmed that the facility failed to demonstrate the development or implementation of an individualized interdisciplinary person-centered care plan that addressed Resident 4's dementia care and behaviors.</p> <p>28 Pa. Code 201.18 (e)(1) Management</p> <p>28 Pa. Code 211.12 (d)(3)(5) Nursing services</p>		