STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395491	A. Building B. Wing	05/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pleasant Valley Manor, Inc	4227 Manor Drive Stroudsburg, PA 18360

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41581 Based on a review of the facility's abuse prohibition policy, select investigative reports, and clinical records, and resident and staff interviews, it was determined that the facility neglected to provide the care and services necessary to avoid physical harm and maintain physical health planned for two residents (Resident 1 and Resident 2) out of six sampled residents. Findings include: A review of the facility policy titled Resident Abuse & Neglect Prevention Program, revealed that management and staff are jointly and individually responsible to ensure each resident shall be free from abuse, neglect, and misappropriation of property. Further policy review revealed that the facilities define neglect as the deprivation by a caretaker of goods or services (failure to provide goods and services) necessary to maintain physical or mental health and avoid physical harm, mental anguish, or mental illness. Clinical record review revealed that Resident 1 was admitted to the facility on [DATE], with diagnoses to include incomplete quadriplegia (severe or complete loss of motor function in all four limbs) and neurogenic bowel (loss of bowel control due to brain or spinal cord damage). A quarterly Minimum Data Set assessment (MDS- a federally mandated standardized assessment process conducted at specific intervals to plan resident care) dated November 8, 2023, indicated that Resident 1 was dependent on facility staff and required the assistance of two staff members for bed mobility (how resident moves to and from lying position, turns side to side, and positions body while in bed) and toilet use (how resident uses the toilet room, commode, bedpan, or urinal and transfers on or off toilet). The resident was cognitively intact with Brief Interview for Mental Status (BIMS - a tool to assess cognitive function) score was 15. Resident 1's plan of care in place for activities of daily living (ADLs) dated April 13, 2023 and updated May 22, 2023, revealed that the resident had a self-care performance deficit due to quadriplegia, limited physical mobility, and limited range of motion. Planned interventions included that Resident 1 would continue with the bowel program nightly and the 11:00 PM to 7:00 AM shift staff were to check that the resident was removed from the bed pan at the beginning of the shift. Resident 1's plan of care, dated April 13, 2023, also indicated that the resident was at risk of developing impaired skin integrity due to decreased mobility with planned interventions for staff to turn and reposition the resident every 2 hours while in bed. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of a progress note dated February 4, 2024, at 7:38 AM revealed that Resident 1 was found lying on the bedpan at 4:30 AM and staff removed the bedpan. A review of a skin/wound note dated February 4, 2024, at 12:33 PM revealed the resident had sustained a 6 cm x 3.5 cm stage 2 pressure wound on his buttocks as the result of being left on the bed pan for an extended period of time. A review of the facility's investigation into the resident's pressure injury, dated February 4, 2024, revealed at 4:30 AM the resident was found lying on the bedpan. Employee 1, LPN, (license practical nurse) noted in the resident's clinical record that staff placed Resident 1 on the bedpan at 9:27 PM on February 3, 2024, and removed the bedpan at 9:36 PM on February 3, 2024. According to the facility's investigation, Employee 1 falsely documented that staff removed the resident from bedpan and failed to notify the 11:00 PM to 7:00 AM nurse that the resident still on the bed pan at change of shift. The investigation also revealed that Employee 2, a nurse aide on the 11 PM to 7 AM shift should have turned and repositioned the resident at 12:00 AM and 2:00 AM and seen that the resident was still on the bed pan. Employee 2 neglected to provide the scheduled turning and repositioning, which would have identified that that the bed pan remained under Resident 1. A review of a witness statement for Employee 2, nurse aide, (no date or time indicated) revealed that the employee did not know the resident was on the bedpan on the 11 PM to 7 AM shift on February 3, 2024 into February 4, 2024. The employee stated she was on break when Employee 3 (a nurse aide trainee) went in to speak to the resident. Employee 2 stated that Employee 3 asked if Resident 1 needed anything and at that time, and the resident stated no. Employee 2 indicated that she found the bedpan under Resident 1 at 4:30 AM on February 4, 2024 . A review of a witness statement from Employee 1, LPN, dated February 4, 2024, at 9:45 AM revealed employee put the resident on the bed pan and alerted the 3:00 PM to 11:00 PM nurse aide that Resident 1 was on the bedpan. The employee stated that she failed to alert the oncoming shift that the resident was on the bed pan. A review of a witness statement from Employee 3, nurse aide trainee, dated February 7, 2024, revealed it was the employee's first night on the nursing unit. The employee stated Employee 2 left for break at 1:00 AM. While Employee 2 was gone on break, Employee 3 stated she checked on Resident 1 but was unaware he was on the bed pan. Employee 3 stated that Employee 2 did not return from her break until 2:15 AM. When Employee 2 returned from her break. Employee 3 and Employee 2 began going through the timed tasks for Employee 3 to familiarize herself with the unit. Employee 2 then asked Employee 3 if she took Resident 1 off the bedpan. Employee 3 indicated she didn't think the resident was on the bedpan. Employee 2 stated to Employee 3 at that time, well the nurse was in here she must have taken him off. Employee 3 stated that Employee 2 failed to check to see if the resident was on the bedpan at that time. An interview with Resident 1 on May 29, 2024, at approximately 12:30 PM revealed the resident was upset regarding the incident. He stated the staff put him on the bedpan after they gave him his bowel protocol on the 3 PM to 11 PM shift on February 3, 2024, and forgot he was on it. The resident stated he was on it most of the night and when the staff finally took him off during the 11 PM to 7 AM shift on, he had a pressure sore on his butt. The resident stated that over the weekend the facility ran out of the Mesalt (a dressing that helps manage wounds) that is used to treat his wound and the facility neglected to provide his wound treatment. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of a physician's order dated May 17, 2024, revealed the following treatment, Collagenase Ointment 250 UNIT/GM apply to right and left ischial wounds topically every dayshift. Cleanse with normal saline, pat dry, apply Santyl (nickel thickness) over slough within wound base, and unfold Mesalt sheet and fluff into wound bed and cover with 4 x 4 secure with ABD pad minimal tape change daily. An interview with Employee 5, Central Supply, on May 29, 2024, at 1:40 PM revealed that Employee 4 messaged her on Sunday May 26, 2024, stating they ran out of Mesalt for Resident 1's wound treatment and asked her how she could obtain it. The employee told Employee 4 she would not be able to order it until Tuesday due to the holiday and she should try and call the pharmacy to see if she can obtain it through them. The employee stated she did not hear anything else about the Mesalt after the conversation with Employee 4. An interview with Employee 4, LPN, on May 29, 2024, at 2:20 PM revealed the employee stated she had provided his wound treatment as ordered for dayshift on May 26, 2024, but used the last of the Mesalt at that time. The employee stated that she messaged Employee 5 about obtaining more Mesalt and was told it could not be ordered until Tuesday May 28, 2024. The employee stated she did not call the pharmacy to see if they have it because it was Sunday, and the pharmacy was closed. The employee stated she had to perform a dressing change later in the day on May 26, 2024, due to the dressing getting soiled. Employee 4 indicated she neglected to provide the resident's full treatment due to the Mesalt not being available. A review of Resident 1's May 2024 Treatment Administration Record revealed on May 27, 2024 Employee 6 LPN sign that performed the treatment. The employee neglected to provide the treatment as she documented due to the Mesalt not being available. There was no documentation that nursing staff consulted with the physician regarding the unavailability of the Mesalt and any desired interim treatment orders until it was available. A review of clinical record revealed Resident 2 was admitted to the facility on [DATE], with diagnoses to include dementia (the loss of cognitive functioning - thinking, remembering, and reasoning - to such an extent that it interferes with a person's daily life and activities) and weakness. An admission Minimum Data Set assessment dated [DATE], indicated that Resident 2 was severely cognitively impaired and was dependent on facility staff and required moderate assistance for activities of daily living. Resident 2's plan of care in place for activities of daily living dated February 29, 2024, revealed a self-care performance deficit related to Alzheimer's disease and impaired balance with planned interventions, for the resident to ambulate and transfer with the assistance of one staff with a rolling walker with a wheelchair to follow and a gait belt. A review of a progress note dated March 27, 2024, at 17:00 (5 PM) revealed that resident fell to the floor, lying on her right side. The fall was witnessed by a staff member who was walking the resident back from the dining room. The staff stated while walking the resident back, she looked away and then looked back to see the resident falling backwards to the floor. A large hematoma was noted to the back right side of the resident's head and swelling was noted around the resident's right eye. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of a facility investigation dated March 27, 2024, revealed Employee 7, a nurse aide, s walking the resident back from the dining room. Employee 7 looked away from the resident and when she looked back Resident 2 fell on to her right side. The employee indicated the resident was using her walker to ambulate. Further investigation revealed the employee neglected to follow the resident's plan of care and did not use a gait belt to ambulate the resident and did not have a wheelchair following the resident while she was walking. The investigation indicated Employee 7 was too far away from the resident to truly be assisting with ambulation. A review of a witness statement from Employee 7 (no date or time indicated) revealed the employee stated that she was with the resident walking with her walker. The employee stated she was looking for water on the floor and heard the noise of the fall. The employee stated the resident was on her back on the floor with the walker still in her hands. A review of a witness statement from Employee 8, LPN, date March 28, 2024, revealed the employee was in the dining room and heard a thud hit the ground outside the dining room. The employee indicted Resident 2 was lying on the floor with the walker in her hands. The employee stated the resident had no gait belt on and the wheelchair was not following behind her as planned. An interview with the Director of Nursing (DON) on May 29, 2024, at approximately 3:00 PM confirmed that staff neglected to provide the care and services necessary to avoid physical harm and maintain physical health for Resident 1 and Resident 2. 28 Pa. Code 201.29 (a)(c) Resident Rights 28 Pa. Code 211.12 (c)(d)(1)(5) Nursing Services

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41581 Based on a review of clinical records and staff interviews it was determined that the facility failed to implement pharmacy procedures to assure timely acquiring and administration of medications to one of six sampled residents (Resident 1). Findings include: Clinical record review revealed that Resident 1 was admitted to the facility on [DATE], with diagnoses to include incomplete quadriplegia (severe or complete loss of motor function in all four limbs) and neurogenic bowel (loss of bowel control due to brain or spinal cord damage). Further review of the resident's clinical record revealed the resident was transferred to the hospital on April 15, 2024, and returned April 22, 2024. The resident had physician orders for: Bactrim DS oral tablet 800-160MG one by mouth every 12 hours at 9:00 AM and 9:00 PM starting April 22, 2024 Prednisone 20MG tablet give three by mouth for one day on April 23, 2024, at 9:00 AM Plavix 75mg tablet give one by mouth daily at 9:00 AM starting April 23, 2024 Vancomycin 125MG capsule give one every 12 hours starting April 23, 2024, at 9:00 AM and 9:00 PM Carvedilol 12.5 MG tablet give one by mouth twice a day starting April 23, 2024, at 9:00 AM and 5:00 PM. A review of Resident 1's April 2024 medication administration record (MAR) revealed the resident did not receive the following medications on the dates below: May 22, 2024 Bactrim 800-160 MG one tablet at 9:00 PM May 23, 2024 Prednisone 20MG 3 tablets at 9:00AM, Bactrim one tablet at 9:00 AM, Vancomycin 125 mg one capsule at 9:00 AM, Plavix 75 MG one tablet at 9:00 AM, and Carvedilol 12.5 MG one tablet at 9:00 AM and 5:00 PM. A review of the clinical record revealed the medications were not administered because they were not available from pharmacy. An interview with the Director of Nursing (DON) on May 29, 2024, at 10:30 AM revealed that the procedure to follow when a medication is not available from pharmacy is to check the emergency supply to see if the medication is available. The DON stated that the physician should be consulted if the medication is not available for further instruction. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's emergency medication supply revealed Bactrim DS, Prednisone, and Carvedilol were all available in the facility's safe stat emergency cart. An interview with Resident 1 on May 29, 2024, at approximately 12:30 PM revealed the resident stated that over the past weekend the facility ran out of the Mesalt (a dressing that helps manage wounds) that is used to treat his wound and as a result he did not receive his wound treatment. A review of a physician's order dated May 17, 2024, revealed the following treatment, Collagenase Ointment 250 UNIT/GM apply to right and left ischial wounds topically every dayshift. Cleanse with normal saline, pat dry, apply Santyl (nickel thickness) over slough within wound base, and unfold Mesalt sheet and fluff into wound bed and cover with 4x4 secure with ABD pad minimal tape change daily. An interview with Employee 9 RN (registered nurse) on May 29, 2024, at 1:30 PM revealed the facility ran out of the resident's Mesalt treatment on Sunday May 26, 2024. Employee 9 stated that at the time of this interview the Mesalt was still not available and they were waiting for the pharmacy delivery. An interview with Employee 5, Central Supply, on May 29, 2024, at 1:40 PM revealed Employee 4 messaged her on Sunday May 26, 2024, stating they ran out of Mesalt for Resident 1's wound treatment and asked her how she could obtain it. Employee 5 told Employee 4 she would not be able to order it until Tuesday due to the holiday and she should try and call the pharmacy to see if she can obtain it through them. The employee stated she did not hear anything else about the Mesalt after the conversation with Employee 4 over the weekend. An interview with Employee 4, LPN, on May 29, 2024, at 2:20 PM revealed that Employee 4 stated that she had provided his wound treatment as ordered for dayshift on May 26, 2024, but used the last of the Mesalt at that time. Employee 4 stated that she messaged Employee 5 about obtaining more Mesalt and was told it could not be ordered until Tuesday May 28, 2024. The employee stated she did not call the pharmacy to see if they had it because it was Sunday, and the pharmacy was closed. An interview with the DON on May 29, 2024, at approximately 2:45 PM revealed the facility staff should have taken the medication from the emergency supply so the resident did not miss any doses of his medications. Further she confirmed there was no documented evidence the physician was consulted regarding the unavailability of the resident's medications and treatments for any further instructions. Interview with the Nursing Home Administrator on May 29, 2024, at approximately 3:00 PM, revealed the facility failed to assure timely acquiring and administration of medications to provide medications and treatments as ordered. 28 Pa. Code 211.12 (d)(1)(3)(5) Nursing services 28 Pa. Code 211.9 (a)(1)(d)(k)(l)(1) Pharmacy services

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41581 Based on review of clinical records and staff interview, it was determined that the facility failed to maintain accurate and complete clinical records, according to professional standards of practice for one of six sampled residents (Resident 1). Findings include: According to the American Nurses Association Principles for Nursing Documentation, nurses document their work and outcomes and provide an integrated, real-time method of informing the health care team about the patient status. Timely documentation of the following types of information should be made and maintained in a patient record to support the ability of the health care team to ensure informed decisions and high quality care in the continuity of patient care: Assessments, Clinical problems, Communications with other health care professionals regarding the patient, Communication with and education of the patient, family, and the patient's designated support person and other third parties. According to the Title 49, Professional and Vocational Standards, Department of State, Chapter 21 State Board of Nursing Subsection 21.11 (a) The register nurse assesses human responses and plans, implements and evaluates nursing care for individuals or families for whom the nurse is responsible. In carrying out this responsibility, the nurse performs all of following functions: (4) Carries out nursing care actions which promote, maintain, and restore the well-being of individuals (6)(b) The registered nurse is fully responsible for all actions as a licensed nurse and is accountable to clients for the quality of care delivered and Subsection 21.18. (a)(5) document and maintain accurate records. According to the Title 49, Professional and Vocational Standards, Department of State, Chapter 21 State Board of Nursing Subsection 21.145. (a) The licensed practical nurse (LPN) is prepared to function as a member of a health-care team by exercising sound nursing judgement based on preparation, knowledge, skills, understanding and past experiences in nursing situations. The LPN participates in the planning, implementation, and evaluation of nursing care in settings where nursing takes place. Clinical record review revealed that Resident 1 was admitted to the facility on [DATE], with diagnoses to include incomplete quadriplegia (severe or complete loss of motor function in all four limbs) and neurogenic bowel (loss of bowel control due to brain or spinal cord damage). An interview with Resident 1 on May 29, 2024, at approximately 12:30 PM revealed the resident was upset about an incident during which staff put him on the bedpan after they gave him his bowel protocol and forgot he was on it. The resident stated he was on the bed pan most of the night and when the staff finally took him off, he had a pressure sore on his butt. The resident stated that over the last weekend the facility ran out of the Mesalt (a dressing that helps manage wounds) that is used to treat his wound and he did not receive his wound treatment as prescribed. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of a physician's order dated May 17, 2024, revealed the following treatment, Collagenase Ointment 250 UNIT/GM apply to right and left ischial wounds topically every dayshift. Cleanse with normal saline, pat dry, apply Santyl (nickel thickness) over slough within wound base, and unfold Mesalt sheet and fluff into wound bed and cover with 4x4 secure with ABD pad minimal tape change daily. An interview with Employee 4 LPN on May 29, 2024, at 2:20 PM revealed the employee stated she had provided the resident's precribed wound treatment as ordered for dayshift on May 26, 2024, and used the last of the Mesalt at that time. Employee 4 stated that she had to perform another dressing change for the resident later in the day on May 26, 2024, because the dressing was soiled. The employee indicated she tried to call the on call physician twice about the Mesalt not being available, but the physician never called the facility back. A review of the resident's clinical record revealed Employee 4 failed to document in the clinical record that there wa no Mesalt available to complete the resident's wound treatment. There was also no documented evidence that Employee 4 attempted to call the resident's physician on two occasions on May 26, 2024, as stated in her interview. Employee 4 failed to document in the resident's treatment record that she changed the resident's wound dressing later in the day on May 26, 2024, due to the dressing becoming soiled. A review of Resident 1's May 2024 Treatment Administration Record revealed that on May 27, 2024 Employee 6 LPN signed the record indicating that she performed the treatment as prescribed despite the unavailability of the Mesalt to complete the treatment as ordered. Employee 6 did not document and consultation with the physician regarding any interim treatment desired due to the unavailability of the Mesalt A review of a facility's investigation dated February 4, 2024, revealed at 4:30 AM staff found Resident 1 lying on the bedpan. Employee 1 LPN (license practical nurse) signed in the clinical record that Resident 1 was placed on the bedpan at 9:27 PM on February 3, 2024, and taken off the bedpan at 9:36 PM on February 3, 2024. The facility's report indicated that Employee 1 falsely documented that staff took Resident 1 off the bedpan on February 3, 2024, at 9:36 PM. An interview with the Nursing Home Administrator on February 6, 2024, at approximately 3:00 PM confirmed that the facility's nursing staff failed to accurately document in the resident's clinical record. 28 Pa. Code 211.5 (f)(iii) Medical records. 28 Pa. Code 211.12 (c)(d)(1)(5) Nursing services.