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	04/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Stroudsburg Post Acute Nursing & Rehabilitationllc	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 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 clinical record review, review of select facility policies, and staff interviews, it was determined that the facility failed to investigate the potential cause of new pressure injuries and failed to consistently implement preventive interventions to avoid the development of pressure injuries for one of five sampled residents (Resident 2). Findings include: A review of a facility policy for Pressure Ulcer/Wound Treatment Protocol and Policy, adopted April 2, 2025 revealed, the purpose of the procedure is to provide guidelines for the care of existing pressure ulcers and the prevention of additional pressure ulcers. General guidelines to include the pressure ulcer treatment program should focus on the following strategies: assessing the resident and the pressure ulcer managing tissue loads pressure ulcer care education and quality improvement. When eschar is present, a pressure ulcer cannot be accurately staged until the eschar is removed. Determine, based on physician order if the resident will be seen weekly by the wound care consultant nurse. Evaluate wound healing weekly and document at a minimum weekly or more often as appropriate. Interventions/care strategies noted that pressure ulcer treatment requires a comprehensive approach, including as appropriate; debridement managing infections managing systemic issues eg.edema(swelling), venous insufficiency(inadequate blood from and to an area) (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	maximizing the potential for healing pain control evaluation of healing and for signs/symptoms of infection. Resident 2 was admitted to the facility on [DATE], with diagnoses that included diabetes mellitus and a history of urinary and bowel incontinence, previously resolved pressure injuries, and long-standing moisture-associated skin damage (MASD inflammation and erosion of the skin caused by prolonged exposure to moisture and its contents, including urine, stool, perspiration, wound exudate, mucus, or saliva) particularly to the sacral and bilateral buttock areas . A quarterly Minimum Data Set (MDS a federally mandated standardized assessment conducted at specific intervals to plan resident care) dated April 3, 2025 , identified the resident as severely cognitively impaired, with a BIMS score of 5 (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 is indicative of severe cognitive impairment), requires staff assistance with activities of daily living and was at risk for pressure sore development. Review of the resident's care plan, initiated February 23, 2021, identified the resident as being at risk for impaired skin integrity due to impaired mobility, neuropathy (dysfunction of one or more peripheral nerves, typically causing numbness and weakness), peripheral vascular disease (condition of blocked blood vessels that reduce blood flow to the limbs usually the legs). Interventions included: AM/PM care with visual skin checks of all skin surfaces (initiated June 25, 2018) Monitoring/documenting/reporting any changes in skin status (initiated June 25, 2018) Education of resident/family/caregivers on causes of skin breakdown (initiated November 30, 2021) Wedge cushion for positioning in bed (initiated March 31, 2021, and October 6, 2022) Staff to offer peri-care after lunch and prior to activities (initiated August 9, 2023) Turn and reposition every 2 hours (initiated August 28, 2023) Toileting plan - check for incontinence and change (initiated December 29, 2023) Despite the care plan interventions, a wound assessment dated [DATE], documented two newly developed pressure injuries: Left ischium (a paired bone forming the lower and back part of the hip bone): unstageable pressure injury, 0. 5 cm x 0.5 cm x 0.1 cm, 100% covered with slough (dead tissue, usually white or yellow in color), with scant serous drainage (clear to yellow fluid that leaks out of a wound) noted. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Right ischium: unstageable pressure injury, 0.2 cm x 0.2 cm x 0.1 cm, 100% covered with slough, with scant serous drainage. Physician orders dated March 3, 2025, directed wound care treatment using SilvaSorb Gel (an antimicrobial wound treatment) with normal saline cleansing and bordered gauze dressings to both ischial areas. Documentation from that date indicated the wound care Certified Registered Nurse Practitioner (CRNP) placed the orders, and the family requested offloading every two hours with pillows. Staff reported that offloading was already occurring however, no documentation substantiated the consistent implementation of this intervention prior to the identification of the wounds. Subsequent wound assessments showed progression of both pressure areas: March 10, 2025: Right ischium: 2 cm x 0.5 cm x 0.2 cm, 80% slough, 20% granulation, scant serosanguineous drainage. Left ischium: 0.7 cm x 1 cm x 0.2 cm, 100% slough, scant serosanguineous drainage. Treatment changed to medical-grade honey with gauze dressings twice daily and as needed. March 17, 2025: Right ischium: 4 cm x 2 cm x 0.2 cm, 100% slough, scant serous drainage. Left ischium: 1.3 cm x 0.5 cm x 0.2 cm, 100% slough, scant serous drainage. Treatment changed to cleanse with normal saline apply Silvadene (topical antibiotic treatment to prevent infection) with gauze dressings twice daily and as needed. March 24 and March 31, 2025: Right ischium: stable at 3.5 cm x 2 cm x 0.2 cm with 100% slough. Left ischium: 0.5 cm x 0.3 cm x 0.2 cm with 100% slough. Treatment remained unchanged. A review of Activities of Daily Living (ADL) documentation revealed the resident was scheduled for showers with skin checks on Sundays (3 PM-11 PM) and Thursdays (7 AM-3 PM). The last documented shower occurred on February 21, 2025. The resident refused a shower on February 28, 2025. There was no documentation of any skin assessment or other documentation indicating the resident's skin was evaluated between February 21 and March 3, 2025, when the ischial wounds were first identified. There was no documented evidence that an investigation into the potential causes of the pressure injuries was initiated following their discovery. Additionally, there was no evidence that the facility reviewed whether preventive interventions were in place and being implemented consistently prior to the development of the wounds. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview conducted on April 15, 2025, at 2:00 PM, the Nursing Home Administrator (NHA) and Director of Nursing (DON) confirmed that an investigation into the cause of the right and left ischial pressure injuries had not been completed. The NHA and DON were also unable to confirm the resident's pressure-relieving interventions had been implemented consistently prior to wound development. 28 Pa Code 211.12 (d)(1)(3)(5) Nursing Services

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26142 Based on clinical record review, facility policy review, and staff interview, it was determined the facility failed to implement non-pharmacological interventions prior to the administration of a narcotic pain medication and failed to ensure that physician orders for the administration of the narcotic pain medication contained clear parameters for use, for one of five sampled residents (Resident 2). Findings include: A review of the facility's policy titled Pain Management, adopted April 2, 2025, indicated the goal of pain management is a pain level of zero or a pain level considered tolerable by the resident and that does not interfere with activities of daily living (ADLs). The policy instructed nursing staff to evaluate and document pain findings every shift on the electronic medication administration record (eMAR) and required that PRN (as needed) pain medications include a documented pain level at the time of administration. Pain was to be assessed using a numerical scale from 1 to 10 (1 representing no pain and 10 representing the most severe pain), or the Pain Assessment in Advanced Dementia scale (PAINAD a tool used to assess pain in individuals with advanced dementia. It involves 5 specific indicators, breathing, vocalization, facial expression, body language, and consolability. The total pain score ranges from zero to 10 points. 1-3 indicates mild pain, 4 to 6 indicates moderate pain, and 7 to 10 indicates severe pain), as appropriate. The policy further specified that non-drug interventions must be attempted prior to the administration of PRN pain medications, with examples including positioning, therapy modalities, relaxation techniques, and diversional activities. Clinical record review revealed that Resident 2 was admitted to the facility on [DATE], with diagnosis to include, diabetes, neuropathy (dysfunction of one or more peripheral nerves, typically causing numbness and weakness), peripheral vascular disease (condition of blocked blood vessels that reduce blood flow to the limbs usually the legs which can cause pain often described as cramping, aching or fatigues. in the legs hips and buttocks.). A quarterly MDS assessment (Minimum Data Set - a federally mandated standardized assessment conducted at specific intervals to plan resident care) dated April 3, 2025 , indicated the resident was severely cognitively impaired, with a BILS score of 5 (Brief Interview for Mental Status a tool to assess the residents attention, orientation and ability to register and recall new information , a score of 0 to 7 indicates severe cognitive impairment), required staff assistance with activities of daily living, and had documented pain. A review of physician's orders dated December 8, 2024, included an order for Tylenol 325 mg (a non-narcotic pain medication), 2 tablets by mouth every 4 hours as needed for pain, not to exceed 4 grams per day. The order instructed staff to attempt non-pharmacological interventions prior to administration, such as distraction, repositioning, warm/cold packs, quiet space, massage, low lighting, or other strategies. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A separate physician's order dated March 28, 2025, prescribed Oxycodone HCl 5 mg by mouth, one tablet every 8 hours as needed for chronic pain, but did not include specific parameters for use, such as pain intensity thresholds or criteria for selecting the opioid over the non-narcotic pain medication. A review of the March 2025 Medication Administration Record (MAR) revealed that Tylenol was administered to Resident 2 on six occasions. Each administration included documentation of attempted non-pharmacological interventions. However, there was no documented pain scale rating at the time of administration, and no clinical rationale documented indicating how nursing staff determined which pain medication (narcotic vs. non-narcotic) was appropriate for each episode of pain. Further review of the March 2025 MAR revealed that on March 29, 2025, at 2:00 PM, a dose of Oxycodone 5 mg was administered for a documented pain rating of 9 out of 10. There was no documented evidence that any non-pharmacological interventions were attempted prior to administering the narcotic pain medication, despite facility policy and physician orders requiring such interventions before PRN use. Additionally, the physician's order lacked defined parameters, such as pain scale thresholds, to guide staff in determining when to administer the opioid. During an interview conducted with the Nursing Home Administrator on April 15, 2025, at 2:00 PM, the Administrator confirmed that non-pharmacological interventions were not documented prior to the administration of the narcotic pain medication on March 29, 2025. The Administrator also confirmed the physician's order for Oxycodone did not contain specific criteria or indications to guide staff on when to administer the narcotic medication. 28 Pa Code 211.12 (d)(3)(5) Nursing Services