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	03/11/2026

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 0569 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify each resident of certain balances and convey resident funds upon discharge, eviction, or death. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of clinical records, resident financial account documentation, billing records, and staff interview, it was determined the facility failed to provide a final accounting of personal funds for one discharged resident (Resident CR1) within 30 days of discharge, in accordance with regulatory requirements, for one of seven residents reviewed for resident funds.Findings include: Clinical record review revealed that Resident CR1 was admitted to the facility on [DATE], and was discharged on September 12, 2025. Review of financial documentation provided by the facility revealed that the resident's responsible party had paid the facility for the month of September 2025 in advance. Documentation provided by the facility included an email dated November 12, 2025, from the Nursing Home Administrator to the resident's responsible party indicating the resident's account had not yet been reconciled because the facility was awaiting payments from other sources and remained pending. Additional documentation revealed that on December 31, 2025, the responsible party received an account statement reflecting a credit balance on the resident's account. However, the facility was unable to provide evidence that this statement represented a final accounting of the resident's funds or that the full status of the account, including all charges, credits, and remaining balance, had been reconciled and clearly conveyed within 30 days following discharge. Review of the billing documentation provided by the facility included account statements covering the period from April 2025 through February 2026. However, the facility was unable to provide documentation demonstrating that a final accounting of the resident's personal funds, including the status of the account balance following discharge, had been provided or was clearly explained to the resident's responsible party within 30 days of the resident's discharge. Interview with the resident's responsible party on March 11, 2026, at 1:00 PM revealed that she had contacted the facility on several occasions to inquire about the status of the resident's account and reported that she did not receive clear information regarding the final status of the account following discharge. The responsible party reported that the last communication received from the facility was the account statement dated December 31, 2025. The responsible party indicated that the information was needed in order to complete financial matters related to the resident's estate. During an interview on March 11, 2026, at 1:45 PM, the Nursing Home Administrator was unable to provide documentation demonstrating that a final accounting of Resident CR1's personal funds, including the status of all charges, credits, and remaining balance, had been completed and conveyed within 30 days following discharge from the facility. The facility's responsibility to complete and convey a final accounting of the resident's personal funds within 30 days of discharge is separate from any requirement related to the disbursement of funds. The facility failed to demonstrate that it reconciled the account and provided a clear and final accounting of Resident CR1's personal funds within the required timeframe. As of the time of the survey in March 2026, the facility had not provided evidence that the final accounting and status of Resident CR1's personal funds had been completed and conveyed within 30 days following discharge. 28 Pa. Code: 201.18 (b)(2)(e)(1) Management. 28 Pa. Code 201.29(a) Resident rights.

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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of clinical records, facility policy, resident interviews, and staff interviews, it was determined the facility failed to develop and implement an individualized discharge planning process that addressed residents' discharge goals and incorporated those goals into the resident's comprehensive care plan for two of seven residents reviewed (Residents 3 and 4). Findings include: A review of Resident 3's clinical record revealed the resident was admitted to the facility on [DATE], with diagnoses including schizophrenia (a severe mental disorder that affects how a person thinks, feels, and behaves and may involve hallucinations, delusions, and disorganized thinking). A review of a quarterly Minimum Data Set assessment (MDS, a federally mandated standardized assessment process conducted periodically to plan resident care) dated January 2 2026, revealed that Resident 3 was cognitively intact with a BIMS score of 15 (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 assessment documented in Section Q (the portion of the MDS used to record resident discharge goals and preferences) that the resident's overall discharge plan was unknown and indicated that no active discharge planning process was occurring for a potential return to the community. A review of Resident 3's comprehensive care plan, initiated September 16, 2025, and reviewed March 11, 2026, revealed the care plan did not include interventions, goals, or planning related to discharge preferences, discharge planning activities, or barriers to discharge. Review of the clinical record and resident information revealed Resident 3 expressed a desire to return to the community and live with his sister. During an interview, the Director of Nursing on March 11, 2026 at 1:30 PM she stated the resident's sister did not want the resident to live with her and the resident had a complex history that made discharge to the community difficult; however, documentation reflecting these discharge considerations, planning activities, or barriers was not incorporated into the resident's care plan. A review of Resident 4's clinical record revealed the resident was admitted to the facility on [DATE], with diagnoses including dementia (a condition characterized by the progressive loss of cognitive functioning, including memory, reasoning, and the ability to perform everyday activities). A review of a quarterly MDS dated [DATE], revealed that Resident 4 was moderately cognitively impaired with a BIMS score of 12 (a score of 8 through 12 indicates moderate cognitive impairment). The MDS indicated in Section Q that the resident's overall discharge plan was unknown and documented that no active discharge planning process was occurring for the resident to return to the community. A review of Resident 4's comprehensive care plan, initiated August 19, 2025, and reviewed March 11, 2026, revealed the care plan did not include discharge planning goals, interventions, or evaluation of discharge options. The clinical record revealed Resident 4 was previously discharged from the facility on June 21, 2025, but returned to the facility on August 19, 2025, following an unsuccessful discharge. Documentation in the record indicated the resident continued to express a desire to return to her home. During an interview on March 11, 2026, at 9:40 A.M., the Social Services Director stated Resident 4 occasionally expressed a desire to return home but the discharge was considered unsafe due to the resident's inability to care for herself and the condition of the home environment, which was described as uninhabitable. The Social Services Director confirmed a discharge care plan addressing the resident's stated preference, barriers to discharge, or alternative discharge options had not been developed. During an interview on March 11, 2026, at 2:15 P.M., the Nursing Home Administrator and Director of Nursing were unable to provide documentation demonstrating individualized discharge care plans had been developed for Residents 3 and 4. 28 Pa. Code 201.29(a) Resident rights. 28 Pa. Code 201.18(e)(1) Management. 28 Pa Code 211.10 (a)(c) Resident care policies.

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of clinical records, select facility policy, observations, and resident and staff interviews, it was determined the facility failed to provide person-centered care as prescribed to meet the resident's current clinical needs and failed to follow physician orders for the management of a Peripherally Inserted Central Catheter (PICC) line for one of 7 sampled residents (Resident 2).Findings include: A review of the facility policy entitled PICC Dressing Change Policy, (PICC, a long, thin tube inserted into a vein and advanced to larger veins near the heart to deliver medications such as antibiotics directly into the bloodstream) last reviewed May 30, 2025, indicated staff are to change the transparent semi-permeable barrier dressing (a covering that allows gases such as oxygen to pass through while preventing bacteria and fluids from entering) every seven days and immediately if the dressing becomes loose, wet, soiled, or non-occlusive (not sealed and allowing fluid or air to pass through), or if bleeding or drainage is present. A review of the facility policy entitled PICC Tubing (IV Administration Set) Change Policy, last reviewed May 30, 2025, revealed staff are to change intermittent administration sets (IV tubing used for medications that are not infused continuously) every twenty-four hours, change needleless connectors every 96 hours or with tubing changes, and maintain a closed system (a system designed to prevent exposure of the IV line to air or contaminants). A review of the clinical record revealed Resident 2 was admitted on [DATE], with diagnoses including a fracture (a break in a bone) of the left leg and active methicillin-susceptible Staphylococcus aureus (MSSA, a type of bacteria that can cause serious infections but is treatable with certain antibiotics). A review of an admission Minimum Data Set assessment (MDS, a federally mandated standardized assessment process conducted periodically to plan resident care) dated February 19, 2026, revealed that Resident 2 was cognitively intact with a BIMS score of 15 (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 through 15 indicates cognition is intact). A review of hospital documentation revealed Resident 2 had a PICC line inserted on February 12, 2026, for long-term intravenous antibiotic therapy. A review of Resident 2's comprehensive care plan, initiated February 16, 2026, and most recently revised February 20, 2026, identified the resident had a PICC line for antibiotic therapy however, the care plan failed to include measurable goals, specific interventions, or monitoring related to PICC line care and intravenous antibiotic administration. Physician orders dated February 18, 2026, directed staff to change the PICC dressing weekly on Tuesdays and as needed. A physician order dated February 18, 2026, directed staff to administer vancomycin (an antibiotic medication used to treat serious bacterial infections) 1000 milligrams (mg) intravenously (IV, within the vein) two times a day until March 25, 2026. A review of a nurse progress note dated February 22, 2026, at 4:04 PM, revealed the PICC line was not patent (not open or allowing fluid to pass through), would not allow infusion of vancomycin, and had been pulled out of the insertion site 5 centimeters (cm, a unit of measurement equal to 0.39 inches). The resident was sent to the emergency room for evaluation.A review of hospital documentation dated February 23, 2026, revealed Resident 2 presented with a PICC line malfunction and required replacement of the catheter. The PICC line was replaced and documented as inserted to 42 cm with 0 cm external at the skin. A review of the clinical record revealed no documented evidence that staff monitored arm circumference (measurement around the arm used to detect swelling that may indicate infection or thrombosis/clot) or measured and documented the external catheter length (the portion of the catheter visible outside the body used to identify movement or displacement), despite known complications with the PICC line. On March 11, 2026, at 10:20 AM, observation of Resident 2 revealed a PICC line in the right arm with a dressing in place (a sterile covering applied to protect the insertion site from contamination). The dressing was peeling at the bottom, contained yellow drainage throughout most of the surface, and was dated February 28, 2026. The date was (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	difficult to read due to the condition of the dressing. Resident 2 stated it had been a long time since the dressing was changed. Employee 1, Registered Nurse Unit Manager, confirmed these observations and acknowledged the dressing should have been changed in accordance with the seven-day requirement and due to visible drainage.At the same time, observation of the IV pole revealed an empty antibiotic bag connected to IV tubing that was not labeled with a date, time, or initials. The tubing was hanging freely without a sterile end cap (a protective sterile cover placed on the end of IV tubing to prevent contamination). Employee 1 Registered Nurse Unit Manager confirmed these observations. Observation revealed no emergency PICC supplies were present in the resident's room. An emergency PICC kit (a set of sterile supplies including a clamp and dressing materials used to quickly secure the catheter if it becomes dislodged, leaks, or breaks) was not available. Clinical record review revealed no physician order or documentation requiring or monitoring the presence of an emergency kit at the bedside. The absence of this equipment increased the risk of delayed response to catheter complications, which may result in bleeding, infection, air entering the bloodstream, or loss of IV access. Employee 1, Registered Nurse Unit Manager, confirmed these observations.A review of the March 2026 Treatment Administration Record (TAR, a record used to document treatments provided to a resident) revealed the dressing change scheduled for March 10, 2026, was documented as completed, however, this documentation was inconsistent with the observed condition of the dressing on March 11, 2026, which remained dated February 28, 2026, and visibly compromised. During an interview on March 11, 2026, at 12:00 PM, the Director of Nursing reviewed and confirmed the above findings, including the failure to maintain the PICC dressing, failure to ensure proper tubing management, lack of monitoring of the catheter, absence of emergency supplies, and inaccurate documentation. 28 Pa Code 211.10 (a)(c) Resident care policies. 28 Pa. Code 211.12 (c)(d)(1)(3)(5) Nursing services.