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	05/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Stroudsburg Post Acute Nursing & Rehabilitationllc	4227 Manor Drive Stroudsburg, PA 18360

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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 - Actual harm Residents Affected - Few	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** Based on a review of the facility's Abuse Prohibition and Neglect Prevention policy, clinical records, physician orders, care plans, medication administration records, facility investigative documentation, and resident and staff interviews, it was determined the facility neglected to provide the care and services necessary to avoid physical harm and maintain physical health for one of nine residents reviewed (Resident 3), resulting in a Stage III pressure injury constituting actual harm due to neglect. Findings include: A review of the facility policy titled Resident Abuse & Neglect Prevention Program, last reviewed by the facility on May 30, 2025, revealed it is the facility policy that the facility has a plan in place to assure appropriate steps are taken to protect each resident from neglect. The policy defined neglect as the failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness. The policy indicated neglect is 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. The policy further indicated neglect refers to failure through inattentiveness, carelessness, or omission to provide timely, consistent, safe, adequate, and appropriate services, treatment, and care. A review of the clinical record revealed Resident 3 was admitted to the facility on [DATE], with diagnoses including incomplete quadriplegia (severe weakness or paralysis affecting all four limbs) and neurogenic bowel (loss of normal bowel control caused by damage to the nervous system). A review of Resident 3's quarterly Minimum Data Set assessment (MDS, a federally mandated standardized assessment process conducted periodically to plan resident care) dated February 19, 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 through 15 indicates cognition is intact). A review of Resident 3's quarterly MDS assessment section GG Functional Abilities revealed the resident was dependent (helper does all of the effort and resident does none of the effort to complete the activity) on staff for bed mobility (the ability to roll from lying on the back to the left and right side and return to lying on the back while on the bed). A review of Resident 3's care plan initiated December 8, 2015, revealed the resident was at risk for impaired skin integrity related to decreased mobility. Interventions initiated on September 13, 2023, directed staff to promptly remove the bedpan (a shallow device used as a portable toilet by individuals confined to a bed, allowing them to urinate or defecate while lying or sitting down) after administration of an enema and discourage the resident from remaining on the bedpan longer than 30 minutes. Additional interventions initiated February 4, 2024, directed nurse aides on the 3:00 PM to 11:00 PM shift to report when the resident was removed from the bedpan. A review of Resident 3's care plan revealed an activities of daily life self-care performance deficit related to limited range of motion, limited mobility, and quadriplegia initiated on December 8, 2015. Interventions initiated on April 7, 2025, directed staff on the 11:00 PM to 7:00 AM shift to check the resident at the beginning of the shift and ensure he was removed from the bedpan. The care plan also directed assistance from two staff members for bed mobility due to the resident's physical (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 0600 Level of Harm - Actual harm Residents Affected - Few	limitations. A review of physician orders revealed an order initiated June 27, 2025, directing the nurse to validate that care was completed by the 11:00 PM to 7:00 AM shift nurse aides, including confirmation the resident was removed from the bedpan, peri-care (cleaning of the genital and buttock area to maintain hygiene and protect the skin) was provided, and bed linens were changed. A review of physician orders further revealed an order initiated April 11, 2025, for Fleet Bisacodyl rectal enema 10 milligrams/30 milliliters (a medication that involves injecting liquid into the rectum to stimulate a bowel movement) at bedtime for constipation (difficulty passing stool). A review of the April 2026 medication administration record revealed Employee 3, Licensed Practical Nurse (LPN), administered Resident 3 a bisacodyl rectal enema on April 24, 2026, at 10:00 PM. A review of the April 2026 medication administration record revealed Employee 3, LPN, documented on April 25, 2026, at 6:00 AM that the resident was off the bedpan and peri-care (cleaning of the genital and buttock area to maintain hygiene and protect the skin) had been provided by the 11:00 PM to 7:00 AM nurse aides. This documentation was completed more than seven hours after the resident had been placed on the bedpan. A review of the facility investigation and documentation provided during survey revealed no documented evidence staff completed the required intervention to verify Resident 3 had been removed from the bedpan during the overnight shift on April 24 through April 25, 2026. A review of a written witness statement from Employee 1, Nurse Aide (NA), revealed she assisted Employee 2, NA, in placing Resident 3 on the bedpan at approximately 10:50 PM on April 24, 2026. Employee 1 NA stated she was informed the resident was alert and oriented and would ring his call bell when he wanted off the bedpan. Employee 1 NA further stated she answered the resident's call bell at approximately 6:30 AM on April 25, 2026, and discovered the bedpan covered by a disposable pad. A review of a written witness statement from Employee 2, NA, dated April 27, 2026, revealed Employee 2 NA provided care to Resident 3 multiple times throughout the night but indicated the resident did not ask to be removed from the bedpan. Employee 2 NA stated Employee 1 NA requested assistance around 6:45 AM on April 25, 2026, to provide care to the resident. A review of facility provided investigative documentation dated April 25, 2026, revealed the on-call nurse responded to Resident 3's concern regarding overnight care. Resident 3 reported he fell asleep on the bedpan overnight and believed staff failed to reposition and remove him from the bedpan. Documentation revealed a full body skin assessment identified a new blister on the resident's coccyx (tailbone, located at the bottom of the spine). Documentation further revealed preventative and protective skin interventions were initiated and the resident was referred to external wound care services. A review of an external wound care progress note dated April 28, 2026, revealed Resident 3 developed a new wound to the coccyx after reportedly being left on a bedpan overnight at the facility on April 24, 2026. The wound was described as beefy red with necrotic tissue (dead tissue caused by loss of blood supply or pressure injury) and yellow discoloration. The wound was identified as a Stage III pressure injury (a full thickness skin wound extending into fatty tissue below the skin) measuring 5.1 centimeters by 11.4 centimeters by 0.3 centimeters with moderate serosanguineous drainage (fluid containing both blood and clear drainage). During an interview on May 5, 2026, at 10:31 AM, Resident 3 explained that staff put him on the bedpan nightly after he is given an enema to help him have a bowel movement. He indicated that he is unable to feel the bedpan because of his condition (quadriplegia affects sensation in the lower body, including the legs, feet, and torso, resulting in numbness, tingling, or a total loss of feeling). Resident 3 explained that about two weeks ago, (April 24, 2025), staff put him on the bedpan sometime after 10:00 PM, and he fell asleep. When he woke in the morning, he didn't realize he was still on the pan until staff provided care in the morning. He indicated that he was upset because he developed a new wound after being left on the bedpan all night. During an interview conducted on May 5, 2026, at 2:30 PM, the above findings were reviewed with the Nursing Home Administrator and Regional Consultant. Facility representatives acknowledged Resident 3 developed a pressure injury after staff failed to remove him from the bedpan overnight on April 24 through April 25, 2026. The facility neglected to provide the necessary care and services to protect Resident 3 from physical harm by failing to (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	implement the resident's plan of care, follow physician orders, and ensure required staff monitoring and repositioning occurred after placement on the bedpan. This neglect resulted in actual harm when Resident 3 developed a Stage III pressure injury to the coccyx measuring 5.1 centimeters by 11.4 centimeters by 0.3 centimeters. 28 Pa. Code 201.29 (a) Resident rights. 28 Pa. Code 201.18 (e)(1) Management. 28 Pa. Code 211.10 (c)(d) Resident care policies. 28 Pa. Code 211.12 (c)(d)(1)(5) Nursing services.

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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** Based on a review of clinical records, air mattress manufacturer guidance, select facility policy, observations, and staff interviews, it was determined the facility failed to consistently implement pressure injury prevention interventions by failing to ensure specialty air mattresses were properly configured and operated according to manufacturer guidance and resident-specific weight parameters for two of nine residents reviewed (Residents 2 and 4).Findings include: A review of facility policy titled Pressure Injury Prevention, last reviewed by the facility on May 30, 2025, revealed it is the facility policy to provide evidence-based preventive skin care and wound treatment to prevent skin complications. The facility will provide pressure redistribution and relief devices (bed support surface) according to interdisciplinary assessment and recommendation. All standard mattresses are pressure-relieving and will be used for all residents unless the provider orders a higher level of pressure reduction or specialty mattress. Air mattress settings will be checked daily. A review of the facility's alternating air mattress manufacturer instruction manual revealed the mattress should first be inflated using the static setting (a temporary setting that keeps the mattress fully inflated during setup) and then changed to alternating mode for operation. Alternating mode continuously changes air pressure within the mattress to help reduce prolonged pressure on the skin and underlying tissue and assist in preventing pressure injuries (damage to the skin or underlying tissue caused by prolonged pressure). When properly indicated and configured, these systems support compliance with evidence-based pressure injury prevention protocols, particularly for high-risk populations, including immobile, bariatric, diabetic, neurologically impaired, and critically ill patients. The manufacturer's instructions further indicated mattress pressure settings should be adjusted according to the resident's weight to ensure appropriate pressure redistribution and support. The manufacturer guidance indicated the following settings based on resident weight:Residents weighing 85 to 140 pounds should be set between levels 1 and 2.Residents weighing 120 to 165 pounds should be set between levels 1 and 3.Residents weighing 150 to 193 pounds should be set between levels 1 and 4.Residents weighing 175 to 205 pounds should be set between levels 2 and 4.Residents weighing 200 to 250 pounds should be set between levels 3 and 5.Residents weighing 245 to 300 pounds should be set between levels 4 and 6.Residents weighing 300 to 350 pounds should be set at level 7. A clinical record review revealed Resident 2 was admitted to the facility on [DATE], with diagnoses that included chronic obstructive pulmonary disease (COPD, a condition caused by damage to the airways or other parts of the lung that blocks airflow and makes it hard to breathe) and chronic kidney disease (gradual loss of kidney function). A review of the care plan initiated on January 20, 2026, revealed Resident 2 had actual skin breakdown related to impaired mobility. Interventions included promote healing without complication include the use of an alternating pressure mattress and administration of treatments as ordered by the physician. A physician's order dated April 23, 2026, directed the use of an alternating pressure mattress (a motorized support surface designed to redistribute pressure through cycles of air inflation and deflation to help prevent and treat pressure injuries). A physician's order dated April 23, 2026, directed staff to check the function and settings of the alternating air mattress daily. A clinical record review revealed Resident 2 weighed 138.2 pounds on May 4, 2026. An observation on May 5, 2026, at 11:22 AM revealed Resident 2 was lying in bed on an alternating pressure mattress. The mattress soft-firm setting was positioned between levels 6 and 7 while the mattress remained on static mode. According to manufacturer guidance, a setting between levels 6 and 7 is intended for residents weighing approximately 245 to 350 pounds. Manufacturer guidance further indicated the static setting should be turned off and the alternating pressure setting activated during operation to ensure pressure redistribution. A clinical record review revealed Resident 4 was admitted to the facility on [DATE], with diagnoses that include chronic obstructive pulmonary disease (COPD). A physician's order for a low air loss concave mattress (a medical device that continuously circulates air to reduce (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	moisture and heat to prevent skin breakdown) was initiated on January 4, 2026, for Resident 4. A review of the care plan initiated on September 7, 2022, revealed Resident 4 had actual or potential impaired skin integrity related to decreased mobility, fragile skin, and incontinence. Interventions included use of a low air loss mattress and administration of treatments as ordered by the physician. A clinical record review revealed Resident 4 weighed 114.8 pounds on April 27, 2026. An observation on May 5, 2026, at 11:30 AM revealed Resident 4 was lying in bed on an alternating pressure mattress. The mattress soft-firm setting was positioned at level 5. According to manufacturer guidance, level 5 is intended for residents weighing approximately 200 to 300 pounds. During an interview on May 5, 2026, at 11:32 AM, Employee 4, Registered Nurse (RN), confirmed Residents 2 and Resident 4's alternating air mattresses were not properly adjusted according to the residents' weights and manufacturer operational guidance. Employee 4 further confirmed Resident 2's mattress remained in static mode rather than alternating pressure mode. During an interview on May 5, 2026, at 2:30 PM, the above findings were reviewed with the Nursing Home Administrator (NHA) and Regional Consultant (RC). The facility failed to ensure Resident 2 and Resident 4's alternating air mattresses were set per manufacturer's operational guidance and resident weight to prevent the development or worsening of pressure injuries. 28 Pa. Code 201.18(b)(1) Management. 28 Pa. Code 211.10(c)(d) Resident care policies. 28 Pa. Code 211.12(c)(d)(1)(3)(5) Nursing services.

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. Based on observations, a review of facility policy, and interviews with staff, it was determined the facility failed to maintain an effective pest control program to ensure the facility was free of insects and pests for one floor out of two floors observed (First Floor). Findings include: A review of the facility policy titled Rodents and Pests, last reviewed by the facility on May 30, 2025, revealed that an exterminator is under contract by the nursing facility and available upon request. During an observation on May 5, 2026, at 11:01 AM, small black flies were observed in multiple areas of the kitchen. Five small black flying insects were observed flying near and on a floor drain to the right of the entrance from the facility hallway. Over 50 small black flying insects were observed flying near and landing on brown cardboard boxes and a clear plastic flour container in the dry storage area. Three small black flying insects were observed opposite the kitchen entrance on a stainless steel table. Additionally, multiple small black flying insects were observed flying throughout the kitchen during a walkthrough between 10:58 AM and 11:10 AM. During an interview on May 5, 2026, at 11:10 AM, Employee 5, dietary director, confirmed the presence of the small flying black insects in the kitchen. Employee 5, the dietary director, explained that the facility is waiting on the pest management company to treat the kitchen. She explained that she was not sure when the small black flies appeared in the kitchen but indicated that they were present for at least two weeks. During an interview on May 5, 2026, at 2:30 PM, the above information was reviewed with the nursing home administrator (NHA) and regional consultant (RC). The RC indicated that the last external pest control company visit was in September 2025. He explained that the facility's maintenance director was replaced and there was a lapse in pest management services. The facility failed to maintain an effective pest control program by allowing a lapse in pest prevention services, resulting in an infestation of small flying black insects in the facility's first-floor kitchen. 28 Pa. Code 201.18 (e)(2.1) Management.