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	07/25/2025

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on review of select facility policy, observations and staff interview, it was determined the facility failed to provide meal service in a manner that maintained the resident's dignity by allowing extended delays in meal delivery at shared tables for seven residents out of 21 sampled (Residents 33, 15, 67, 35, 2, 23, and 37)Findings include:Review of the facility policy titled Resident Rights last reviewed by the facility on May 30, 2025, revealed the facility will make every effort to assist each resident in exercising his/her rights to assure that the resident is always treated with respect, kindness, and dignity. An observation conducted on July 22, 2025, at 12:10 PM, revealed Residents 33, 15, 67, and 35 were seated together at Dining Table #5 in the main dining room. At 12:20 PM, Resident 35 was served her lunch meal and began eating. The other residents seated at the same table remained without meals. Staff continued serving lunch to other residents in the dining room. At 12:35 PM 15 minutes after Resident 35 received her meal Resident 67 was served. At 12:40 PM 20 minutes after Resident 35 was served Residents 15 and 33 were provided with their meals. Additional observation on July 22, 2025, at 12:33 PM, revealed Residents 2, 23, and 37 were seated together at Dining Table #4. Resident 2 was served her lunch at 12:33 PM. Resident 23 received her meal at 12:43 PM, and Resident 37 at 12:46 PM 13 minutes after the first resident at that table was served.During an interview conducted on July 22, 2025, at 12:50 PM, Employee 5 (nurse aide) reported that there were not enough staff members assigned to the dining room to ensure timely delivery of meals and assistance. Employee 5 further stated the meal trays are not organized by table but are randomly placed on the meal cart, which delays service to some residents at shared tables.During an interview conducted on July 23, 2025, at 12:20 PM the observations were reviewed with the Nursing Home Administrator and Director of Nursing, and they confirmed the lunch meal service in the main dining room was not conducted in a timely or coordinated manner.The facility failed to ensure that residents were provided meals in a dignified manner by allowing extended delays in meal service for residents seated at the same dining table.28 Pa. Code 211.12 (c)(d)(1)(3)(5) Nursing services.

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 0577 Level of Harm - Potential for minimal harm Residents Affected - Many	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. Based on observation and resident and staff interviews, it was determined that the facility failed to ensure the most recent Department of Health survey results were readily accessible to residents and visitors for two out of the two nursing units (Nursing Units 1 and 2) and experiences reported by 4 out of 4 residents interviewed during a group interview (Residents 42, 47, 51, and 67).During a resident council interview on July 23, 2025, at 10:00 AM, four alert and oriented residents in attendance (Residents 42, 47, 51 and 67) indicated they did not know where the facility posted the Department of Health survey results.During an observation and facility tour on July 23, 2025, at 11:00 AM on Nursing Units 1 and 2, the Department of Health survey results were not able to be located.During an interview on July 24, 2025, at approximately 10:30 AM, the Director of Nursing (DON) and Nursing Home Administrator (NHA) acknowledged the Department of Health survey results were posted on Nursing Units 1 or 2. The facility failed to ensure Department of Health survey results were readily accessible to residents and visitors.28 Pa. Code 201.14(a) Responsibility of licensee.

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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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and staff interview, it was determined the facility failed to develop and implement a baseline care plan within 48 hours for two of 17 residents reviewed that were admitted during the prior 30 days (Residents 88 and 90). Findings include: A review of Resident 88’s clinical record revealed that the resident was admitted to the facility on [DATE], with diagnoses that included End-Stage Renal Disease (ESRD) the final stage of chronic kidney disease where the kidneys can no longer function adequately, requiring dialysis (a medical process that filters waste and excess fluid from the blood) or a kidney transplant for survival and diabetes mellitus, a chronic condition characterized by elevated blood glucose (sugar) levels over an extended period. A nursing progress note dated July 17, 2025, at 11:19 PM, documented that the resident was alert and oriented, was actively receiving dialysis, and had a fistula on her left arm (a surgically created connection between an artery and a vein to provide dialysis treatments). The note further indicated the presence of redness beneath both breasts, closed and healed areas with scarring on the buttocks, and the resident was incontinent of bowel and bladder (unable to control urination or bowel movements). The note also indicated the resident was scheduled to be evaluated by Physical Therapy and Occupational Therapy to assess her mobility, transfer status, and fall risk. Review of the resident’s baseline care plan, initiated on July 18, 2025, showed that a dialysis plan of care had been developed. However, a subsequent review on July 23, 2025, revealed the baseline care plan did not address the resident’s other immediate significant care needs, including her incontinence status, skin integrity concerns, mobility limitations, and the need for fall prevention strategies. The care plan failed to provide specific guidance to staff on how to manage these known issues to ensure the provision of safe, effective, and person-centered care during the initial days of the resident’s stay, prior to the completion of the comprehensive care plan. Interview with the Director of Nursing (DON) on July 24,2025, at approximately 2:00 PM was conducted to review the above findings related to failure to ensure this resident's baseline care plan included the minimum healthcare information necessary to properly care for this resident immediately upon his admission, which would address this resident's specific health and safety concerns to prevent decline or injury. A clinical record review revealed Resident 90 was admitted to the facility on [DATE], with diagnoses that included paraplegia (a condition characterized by the loss or impairment of motor and sensory functions in the lower half of the body). An admission falls risk assessment dated [DATE], revealed Resident 90 was at risk for falls with risk factors that included being bedbound and requiring regular assistance with elimination. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An occupational therapy evaluation dated June 23, 2025, revealed Resident 90 was totally dependent on staff for bed mobility and lower body dressing. The evaluation indicated Resident 90 presented with deficits to bilateral upper extremity strength, balance, coordination, functional activity tolerance, and current level of functioning, placing her at risk for falls. The evaluation also indicated that due to the resident’s documented physical impairments and associated functional deficits, the resident was at risk for falls. A review of Resident 90’s care plan revealed no documented evidence that interventions to mitigate Resident 90’s risk for falls were developed or implemented following the nursing or occupational therapy evaluations indicating the resident was at risk for falling. During an interview on July 24, 2025, at 12:05 PM, the Director of Therapy explained that based on the occupational therapy evaluation dated June 23, 2025, and the resident’s physical limitations and size, Resident 90 would require two staff to safely move the resident in bed for care, changing, and hygiene. The Director of Therapy indicated that after therapy evaluates a resident’s strengths and needs, nursing reviews the information and implements the resident’s needs into a plan of care for facility staff to follow. Further review of the care plan revealed no documented evidence to direct staff that Resident 90 would require two staff to safely move her while in bed. During an interview on July 25, 2025, at approximately 10:45 AM, the Director of Nursing (DON) and Nursing Home Administrator (NHA) were not able to provide documented evidence that the minimum health care information necessary to properly care for Resident 90 was developed or implemented into her baseline plan of care. The NHA and DON were unable provide evidence that Resident 90’s baseline care plan identified that she was at risk for falls or updated to include therapy recommendations for two staff to safely move the resident in bed for care, changing, and peri hygiene. Refer F689 28 Pa. Code 201.18 (b)(1) Management. 28 Pa. Code 211.10(c) Resident care policies. 28 Pa. Code 211.12(d)(1) Nursing services.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of clinical records, select facility policy, and staff interviews, it was determined the facility failed to provide nursing services consistent with professional standards of quality to ensure that licensed nurses properly evaluated and provided nursing care according to physician orders for one resident out of 21 residents reviewed (Resident 20). Findings include:A review of a facility policy titled Medication Administration, last reviewed on May 30, 2025, revealed that it is the policy of the facility to provide a secure and safe method of administering medications to the residents.According to the Pennsylvania Code, Title 49, Professional and Vocational Standards, State Board of Nursing, 21.11 (a)(1)(2)(4) indicates that the Registered Nurse (RN) was to collect complete ongoing data to determine nursing care needs, analyze the health status of individuals and compare the data with the norm when determining nursing care needs, and carry out nursing care actions that promote, maintain, and restore the well-being of individuals.The Pennsylvania Code, Title 49, Professional and Vocational Standards, State Board of Nursing, 21.145 Functions of the Licensed Practical Nurse (LPN) (a) The LPN is prepared to function as a member of the health care team by exercising sound judgment based on preparation, knowledge, skills, understandings, and past experiences in nursing situations. The LPN participates in the planning, implementation, and evaluation of nursing care in settings where nursing takes place. 21.148: Standards of nursing conduct (a) A licensed practical nurse shall: (5) document and maintain accurate records.A review of clinical records revealed Resident 20 was admitted to the facility on [DATE], with diagnoses to include hypertension (blood pressure that is higher than normal) and atrial fibrillation (a condition that causes the heart to beat irregularly and occasionally much faster than normal).A quarterly Minimum Data Set Assessment (MDS-a federally mandated standardized assessment conducted at specific intervals to plan resident care) of Resident 20 dated May 29, 2025, revealed the resident was severely cognitively impaired with a BIMS score of 06 (brief interview for mental status, a tool to assess the residents' attention, orientation, and ability to register and recall new information; a score of 0-7 indicates severe cognitive impairment).A clinical record review for Resident 20 revealed a physician's order dated April 30, 2025, remaining current at the time of the survey, for Metoprolol tablet (used to treat high blood pressure) 100 milligrams (mg). Give one tablet by mouth twice a day for hypertension and hold this medication if the resident's systolic (top number the pressure in the arteries when the heart pushes the blood out) blood pressure is less than 100 millimeters of mercury (mm Hg), or heart rate is less than 60 beats per minute.A review of Resident 20's Medication Administration Records (MAR) dated May 2025 failed to provide evidence that Resident 20's blood pressure or heart rate was monitored prior to the administration of the antihypertensive medications from May 1, 2025, to May 31, 2025. A review of Resident 20's MAR dated June 2025 failed to provide evidence that Resident 20's blood pressure or heart rate was monitored prior to the administration of the antihypertensive medications from June 1, 2025, to June 14, 2025, 9:00 A.M.A review of Resident 20's MAR dated July 2025 revealed that metoprolol was held on July 17, 2025, due to parameters, despite Resident 20's blood pressure being 104/65 and heart rate 63, above the hold parameters ordered.Further review revealed the metoprolol was held on July 23, 2025, due to parameters, despite Resident 20's blood pressure being 107/55 and heart rate 71, above the hold parameters ordered.The above findings were reviewed with the Director of Nursing and Registered Nurse Assessment Coordinator on July 25, 2025, at approximately 9:00 A.M., and confirmed the physician's orders were not followed as ordered.28 Pa. Code 211.10(d) Resident care policies.28 Pa. Code 211.12(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. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, a review of clinical records, select facility policy, and resident and staff interviews, it was determined the facility failed to implement interventions to prevent the development of a pressure injury for one resident out of 21 sampled (Resident 1). Findings include: A review of the facility policy titled Pressure Ulcer Prevention, last reviewed by the facility on May 30, 2025, revealed it is the facility's policy to promote healthy intact skin, educate patients and/or significant others about pressure ulcer prevention, identify at-risk residents, and implement appropriate skin care treatments as determined by the Registered Nurse (RN) or designated skin care provider. A clinical record review revealed Resident 1 was admitted to the facility on [DATE], with diagnoses that included diabetes (a chronic disease that occurs either when the pancreas does not produce enough insulin or when the body cannot effectively use the insulin it produces) and peripheral vascular disease (a condition in which narrowed arteries reduce blood flow to the arms or legs). A review of a quarterly Minimum Data Set assessment (MDS- a federally mandated standardized assessment process conducted periodically to plan resident care) dated June 19, 2025, revealed that Resident 1 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). A review of Resident 1's care plan revealed the resident has potential/actual impairment to skin integrity/risk of pressure areas related to decreased mobility, fragile skin, peripheral vascular disease, and a history of ulceration to the left extremity initiated on November 19, 2024. Interventions included identifying causative factors and eliminating/resolving where possible and following facility protocols for treatment of injuries initiated on November 19, 2024. A clinical record review revealed a Braden Scale for predicting pressure injury assessment dated [DATE], indicating Resident 1 was at risk of developing pressure injuries. An external wound evaluation and management summary dated June 20, 2025, indicated Resident 1's Stage 3 left heel pressure injury (a type of wound characterized by complete skin loss, extending into subcutaneous tissue) was resolved after a duration of 75 days. The document indicated additional care plan items with recommendations to float heels in bed, turn the resident from side-to-side in bed, reposition per facility protocol, and use a pressure off-loading boot (a specialized type of footwear designed to minimize or eliminate pressure on specific areas of the foot, particularly the heel, to promote healing and prevent further damage to wounds or ulcers). An external wound evaluation and management summary dated July 18, 2025, indicated Resident 1 developed a new diabetic wound (a breakdown of the skin and sometimes deeper tissues of the foot) that led to a pressure sore formation on the left heel. The wound provider estimated the duration of the injury was less than 5 days. The summary described the wound as measuring 0.6 cm x 0.3 cm x 0.2 cm, with a maceration of the peri-wound (white and soggy area surrounding the wound), moderate serous exudate (a type of wound drainage that is typically thin, clear, and watery), and having 50% slough (dead, non-viable tissue that accumulates in a wound) and 50% granulation tissue (new connective tissue that forms in a wound during healing). The external wound evaluation and management summary dated July 18, 2025, indicated specific to visit recommendations, which included a recommendation for a pressure off-loading boot. During an observation on July 22, 2025, at 10:57 AM, Resident 1 was lying supine in his bed with his heels directly on the mattress. Two off-loading heel boots were on the floor near the door-side nightstand. During an interview on July 22, 2025, at 10:57 AM, Resident 1 explained that sometimes staff put the boots on him and sometimes they do not. He indicated he currently has a sore on his foot, and he wears the boots when staff puts them on his feet. A review of Resident 1's medical record revealed no current documented evidence of a current intervention for the resident to wear off-loading boots as recommended by the wound care provider. During an interview on July 23, 2025, at 8:50 AM, Employee 3, Registered Nurse Assessment Coordinator (RNAC), confirmed Resident 1's order and indicated the care plan was not updated to include off-loading boots as recommended by the wound care provider on June 20, 2025, or more recently on July 18, 2025. During an observation on July 24, 2025, at 9:50 AM, Employee 4, Registered Nurse (RN), provided wound care to Resident 1's left heel. Resident 1's wound measured 0.5 cm x 0.4 cm x 0.1 cm. The wound had no odor or drainage. The wound bed was intact and pink. The resident indicated that he had some pain in the area of the wound. The above findings were reviewed during an interview on July 25, 2025, at approximately 11:00 AM, with the Nursing Home Administrator (NHA) and Director of Nursing (DON) and they were not

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of clinical records, select facility policies, documentation provided by the facility, and staff interviews, it was determined the facility failed to implement necessary safety interventions for one of 21 residents reviewed (Resident 90), who had been identified as at risk for falls which resulted in actual harm, bilateral periprosthetic knee fractures.Findings include:A review of the facility policy titled Falls and Fall Risk Management, last reviewed by the facility May 2025, revealed it is the facility's policy that based on previous evaluations and current data, staff will identify interventions related to the resident's specific fall risk and causes to try to prevent the resident from falling and to try to minimize complications from falling. Also, the policy indicated that the interdisciplinary team, with the input of the attending physician as appropriate, will identify appropriate intervention to reduce the risk of falls.A clinical record review revealed Resident 90 was admitted to the facility on [DATE], with diagnoses that included paraplegia (a condition characterized by the loss or impairment of motor and sensory functions in the lower half of the body). An admission falls risk assessment dated [DATE], identified the resident was at high risk for falls, due to being bedbound and dependent on staff for assistance with elimination.A physician's order for oxycodone HCl oral tablet (an opioid analgesic medication) with directions to give 1 tablet by mouth every 8 hours for pain was initiated on June 23, 2025.An Occupational Therapy (OT) evaluation dated June 23, 2025, documented that Resident 90 had serious physical limitations, including weakness in both arms, poor balance, and low activity tolerance. The evaluation concluded that Resident 90 was at risk of falling and required full assistance from staff for bed mobility and lower body dressing. The therapist recommended that two staff members be present to safely move the resident in bed due to her physical condition and care needs.This recommendation was confirmed during an interview conducted on July 24, 2025, at 12:05 PM, with the Director of Therapy, who explained the recommendation for two staff was based on the resident's physical size and functional limitations. The Director stated that after therapy staff evaluate a resident's needs, it is the responsibility of the nursing department to review those recommendations and make sure they are included in the resident's care plan, so that direct care staff know what assistance is required.However, a review of the Resident 90's care plan showed no documented evidence the recommendation for two staff to assist with in-bed care was ever added. The care plan did not include this information, even though both the therapy and nursing evaluations identified the resident as needing more help to safely receive care in bed, specifically that two staff members were needed for bed mobility. As a result, staff were not given clear instructions on how many people were needed to safely care for the resident in bed or to help reduce the chance of a fall.Progress notes dated June 26, 2025, at 8:40 PM, documented that Resident 90 sustained a fall during the shift. According to the note, while Employee 1, a Nurse Aide (NA), was changing the resident following a bowel movement, the resident's legs slid off the side of the bed. The aide lowered the resident to the floor, and staff used a mechanical lift to return the resident to bed. The resident complained of pain in the left knee, rated as 10 out of 10 on the pain scale (0 indicating no pain and 10 indicating the most severe pain). The note indicated the resident's skin was intact, with no redness or bruising noted at the time. The physician and family were notified, and the resident was sent to the emergency department for evaluation.A review of the Medication Administration Record (MAR) for June 2025 confirmed that on June 26, 2025, at 9:38 PM, Resident 90 was administered oxycodone HCl 5 mg (a narcotic pain medication) in response to the reported pain level of 10 out of 10.During an interview on July 24, 2025, at 11:55 AM, Employee 2, a Licensed Practical Nurse (LPN), recalled he was working the 3:00 PM to 11:00 PM shift on June 26, 2025. Employee 2, LPN, explained he was alerted by a female nurse aide (unable to recall name) that Resident 90 was falling from the bed. Employee 2, LPN, recalled Resident 90 on the floor when he responded to the room. He indicated he did not see the resident fall. Resident 90 was on the floor when Employee 2, LPN, entered the room. He instructed the nurse aides to obtain a mechanical lift to transfer the resident back to bed. He did not recall if the resident was in pain following the fall.During an interview on July 24, 2025, at 1:30 PM, Employee 1, NA, explained that on June 26, 2025, at approximately 3:30 PM, Resident 90 needed to be cleaned and changed after having a bowel movement. Employee 1, NA, recalled the care plan on that day indicated that Resident 90 only needed the assistance of one staff for bed mobility and hygiene. Employee 1, NA, explained that it was difficult to change and clean Resident 90 because she was not able to hold a position. She needed to reposition the resident a few times to get a good angle to clean her. While providing

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, clinical record review, facility policy review, and staff interviews, it was determined the facility failed to ensure that appropriate physician's orders, a documented medical justification, and an individualized plan of care were in place for the use and management of an indwelling urinary catheter for one of 21 residents reviewed. (Resident 87).Findings include:A review of a facility policy titled Urinary Foley Catheter Care, last reviewed by the facility on May 30, 2025, revealed it is the policy of the facility that all residents who are either admitted , readmitted , or having an indwelling urinary catheter inserted or changed will have the procedure documented in the medical record by the licensed nurse. The licensed nurse will also document in the Medication Administration Record (MAR) the size of the Foley catheter, the balloon size, and any special instructions, and that appropriate nursing personnel will provide catheter care within the scope or function of their practice. Further review revealed that Foley catheter care is performed appropriately to prevent complications due to the presence of an indwelling urethral catheter, and the need for catheter care will appear on the resident care plan.A review of Resident 87's clinical record revealed that the resident was admitted to the facility on [DATE], with a diagnosis that included acute cystitis (a bladder infection characterized by inflammation of the bladder lining), and with an indwelling Foley catheter in place. A Foley catheter is a thin, flexible tube inserted into the urethra and guided into the bladder to allow for continuous drainage of urine.A review of a quarterly Minimum Data Set assessment (MDS a federally mandated standardized assessment process conducted periodically to plan resident care) dated July 18, 2025, revealed that Resident 87 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). Despite the resident being admitted with an indwelling Foley catheter, there was no documentation in the care plan dated July 18, 2025, reflecting the presence of the catheter or the need for catheter-related care.A review of the resident's TAR (treatment administration record) for July 2025 revealed no entries documenting the presence of the catheter, its size, balloon volume, or instructions for nursing care. Additionally, review of the resident's physician orders failed to reveal any documentation indicating the use of the catheter or outlining medical justification for its presence.On July 22, 2025, at 11:00 A.M., an observation of Resident 87 revealed the resident had a Foley catheter in place. During an interview conducted at the same time, the resident stated he had been admitted with the catheter. However, the facility had no documented physician order, no documented care plan interventions, and no documented justification for the use of the catheter at the time of the surveyor's observation. It was not until July 23, 2025, five days after admission and only after surveyor inquiry, that the facility obtained a physician order for the catheter and initiated documentation of related care.An interview with the Director of Nursing and Registered Nurse Assessment Coordinator confirmed the absence of a physician order and a plan of care for Resident 87's Foley catheter use.28 Pa. Code: 211.12 (c)(d)(1)(3)(5) Nursing Services.

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	07/25/2025

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation and staff interview, it was determined the facility failed to maintain acceptable practices for the storage and service of food to prevent the potential for contamination and microbial growth in food, which increased the risk of food-borne illness in the food and nutrition services department. Findings include:Food safety and inspection standards for safe food handling indicate that everything that comes in contact with food must be kept clean and food that is mishandled can lead to foodborne illness. Safe steps in food handling, cooking, and storage are essential in preventing foodborne illness. You cannot always see, smell, or taste harmful bacteria that may cause illness according to the USDA (The United States Department of Agriculture, also known as the Agriculture Department, is the U.S. federal executive department responsible for developing and executing federal laws related to food). Observation during the initial tour of the food and nutrition services department on July 22, 2025, at 10:45 AM revealed a tray of seven (7) thawed 4-ounce nutritional shakes on a shelf in the walk-in refrigerator. The defrost date on the shakes was June 5, 2025. The manufacturer's label specified the product must be used within 14 days of thawing. As of the date of observation, the shakes had been thawed for over six (6) weeks, well beyond the recommended use period, posing a risk for microbial growth and potential foodborne illness. Continued observation of the walk-in refrigerator revealed a one-gallon container of salad dressing, which was opened but with no date of opening, and a one-gallon container of BBQ sauce, which was opened but with no date of opening. During an interview with the Food Service Director (FSD) at the time of the observation, it was stated that both products are considered safe for up to three (3) months after opening if kept refrigerated. However, the absence of opening dates prevents the ability to determine product viability, representing a failure in proper food labeling and tracking procedures. Further observation of the walk-in refrigerator revealed a 32-ounce carton of liquid eggs, which was opened but not dated. Manufacturer's instruction indicated the product must be used within three (3) days after opening. The absence of opening dates prevents the ability to determine product viability. During an interview conducted on July 22, 2025, at 11:00 AM the FSD confirmed that food and beverages are expected to be labeled, dated, stored, and thawed in accordance with food safety standards. The facility failed to ensure that food was labeled, stored, and used within safe timeframes, in accordance with federal food safety standards and the manufacturer's guidelines. 28 Pa. Code 201.18 (e)(2.1) Management.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of the facility's plan of correction from the survey ending July 25, 2025, the documented outcomes of the facility's Quality Assurance and Performance Improvement (QAPI) committee, observations, clinical record reviews, and staff interviews, it was determined the facility failed to ensure its quality assurance program effectively identified and addressed recurring deficient practices related to the development and implementation of resident baseline care plans (Residents 1 and 10) and nursing services consistent with professional standards of quality to ensure that licensed nurses properly evaluated and provided nursing care according to physician orders (Residents 1, 9 and 16). Findings include: As a result of the deficiencies cited under the requirements related to the development and implementation of resident baseline care plans and nursing services consistent with professional standards of quality to ensure that licensed nurses properly evaluated and provided nursing care according to physician orders during the survey of July 25, 2025, the facility developed a plan of correction to serve as their allegation of compliance, which included a quality assurance monitoring component to ensure that solutions were sustained. This corrective plan was to be completed and functional by August 6, 2025. However, during the survey ending August 27, 2025, continuing deficient facility practice was identified with these same requirements.According to the facility's plan of correction for the deficiency cited on July 25, 2025, relating to the development and implementation of resident baseline care plans, procedures implemented to ensure deficient practice was corrected included (1) Baseline care plans were completed for the two identified residents, and (2) new admissions to the facility have the potential to be affected. Nursing staff educated on the requirement of a baseline care plan. (3) The Director of Nursing will randomly audit admission charts to ensure the baseline care plan was initiated twice weekly for four weeks, then four times a month for four months. (4) Audit results will be reviewed and evaluated at quality assurance performance improvement committee meetings over the next four meetings, and interventions adjusted as needed.A clinical record revealed Resident 1 was admitted to the facility on [DATE].A clinical record review revealed Resident 10 was admitted to the facility on [DATE].A clinical record review revealed the facility developed a baseline plan of care interventions related to Resident 1's indwelling medical device for dialysis and infection control procedures to mitigate the resident's risk for infection; however, observations made during the onsite survey on August 27, 2025, revealed that the facility failed to implement the baseline plan of care interventions.A clinical record review revealed that the facility failed to develop and implement a baseline care plan that adequately addressed Resident 10's need for safe transfer and bed mobility.A review of facility quality assurance and performance improvement activities failed to reveal documented evidence that identified Resident 1's and Resident 10's baseline care plans were developed and/or implemented to ensure the residents received the individualized care and services needed. According to the facility's plan of correction for the deficiency cited on July 25, 2025, relating to the development and implementation of resident baseline care plans, procedures implemented to ensure deficient practice was corrected included (1) Physician orders could not be followed retroactively on identified residents, and (2) any resident receiving medication with administration parameters has the potential to be affected. Licensed nursing staff were educated on the requirement to follow physician orders. The facility will reinforce education on the medication order-taking process to emphasize transcription, reading back and verification, and carrying out and documenting. (3) The Director of Nursing or designee will randomly audit three charts weekly for four weeks and then monthly for 3 months for compliance with medication parameters and the medication order-taking process to emphasize transcription, readback and verification, and carrying out and documentation. (4) Audit results will be reviewed and evaluated at quality assurance performance improvement committee meetings over the next four meetings, and interventions adjusted if needed.A clinical record review revealed that Resident 16 was admitted to the facility on [DATE].A clinical record review revealed that Resident 9 was admitted to the facility on [DATE].A clinical record review revealed that licensed nurses failed to properly evaluate and/or provide nursing care according to physician orders for Residents 1, 9, and 16.A review of facility quality assurance and performance improvement activities failed to reveal documented evidence that the facility identified Residents 1, 9, and 16 as having the potential to be affected by the aforementioned deficient practice and/or ensured licensed nurses properly evaluate and provide nursing care according to physician's orders.During an interview on August 27, 2025, at approximately 1:00 PM, the Director of Nursing (DON) and Nursing Home Administrator confirmed the

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F 0926 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have policies on smoking. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, a review of clinical records and select facility policy, and resident and staff interviews, it was determined the facility failed to implement procedures for smoking safety and safety of smoking areas, as evidenced by one out of the two residents sampled who smoke (Resident 39).A review of the facility policy titled Smoking/Vaping Policy, last reviewed by the facility on May 30, 2025, revealed it is the policy of the facility to maintain an environment that promotes the safety and well-being of our residents, employees, and visitors through established processes that support this goal. The policy indicates for residents an initial resident smoking assessment will be completed upon admission for all residents who smoke or vape. Safety considerations for each resident include, but are not limited to, whether the resident requires assistance, the extent of assistance or supervision required, and any restrictions or special equipment that might be needed to ensure safety. The interdisciplinary team will meet on a quarterly basis or with any change in a resident's condition that may affect their ability to smoke safely. Matches and lighters must be kept at the nurse's station. Approved ash containers of noncombustible material and safe design will be provided in designated smoking areas. A clinical record review revealed Resident 39 was admitted to the facility on [DATE], with diagnoses that included rheumatoid arthritis (an autoimmune disease that primarily causes inflammation of the joints) and mononeuropathy (a condition where damage occurs to a single peripheral nerve). A review of Resident 39's plan of care revealed she is a smoker, not a smoking safety risk, and does not need to be supervised, initiated on July 13, 2018. Interventions included observing clothing and skin for cigarette burns. A safe smoking assessment dated [DATE], revealed Resident 1 is able to access the smoking area independently and is safe to smoke without supervision. The assessment also indicated that the resident is able to extinguish smoking materials completely in an appropriate receptacle. A review of a quarterly Minimum Data Set assessment (MDS-a federally mandated standardized assessment process conducted periodically to plan resident care) dated May 29, 2025, revealed that Resident 39 is 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). An observation and interview on July 22, 2025, at 12:00 PM revealed Resident 39 smoking in the designated smoking area. Resident 39 was using a plastic cup to collect the ashes from her lit cigarette. Resident 39 was wearing a teal shirt with multiple small holes in the upper right portion of the shirt. Resident 39 explained the holes in her shirt were old burn marks. Resident 39 indicated it is hard for her to utilize the facility-provided ash receptacles, so she uses a plastic cup. During an observation and interview on July 22, 2025, at 2:30 PM, Resident 39 was observed with her cigarette and a blue lighter in her room. The lighter was stored in her cigarette pack. The cigarette pack was in the cup holder on her motorized wheelchair. Resident 39 explained she is an independent smoker and can keep the lighter secured in her room. During an interview on July 25, 2025, at approximately 11:00 AM, the Director of Nursing (DON) and Nursing Home Administrator (NHA) were not able to provide documented evidence the facility implemented their protocol for safe smoking by ensuring lighters and matches were secured at the nurse's station. The DON and NHA were unable to provide documented evidence that the plastic cup Resident 39 was utilizing as an ashtray was a designated ashtray and safe for cigarette butts and ashes. The DON and NHA were unable to provide documented evidence that facility staff identified Resident 39's shirt to have possible burn holes until inquiries were made during the survey.28 Pa. Code 201.18 (b)(1)(e)(1) Management.28 Pa. Code 209.3 (a) Smoking.