STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395493	A. Building B. Wing	08/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Julia Ribaudo Extended Care Center	1404 Golf Park Drive Lake Ariel, PA 18436

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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from medications that restrain them, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48277 Based on clinical record review and staff interviews it was determined that the facility failed to ensure that one resident out of five sampled was free of chemical restraints used to most readily control the resident's behavior and not required to treat the resident's medical symptoms (Resident B1). Findings include: A review of Resident B1's clinical record revealed that the resident was admitted to the facility on [DATE], with diagnoses that included unspecified dementia (a group of symptoms that affects memory, thinking and interferes with daily life), unspecified psychosis (is the term for a collection of symptoms that happen when a person has a disconnection from reality and can occur due to different mental and physical conditions), and insomnia. An annual Minimum Data Set assessment (a federally mandated standardized assessment completed periodically to plan resident care) dated May 8, 2024, indicated that the resident was severely cognitively impaired with a BIMS (brief interview to assess cognitive status) score of 00 (00-07 represents severe cognitive impairment) and that the resident was independent with ambulation. Section E0900 Wandering-Presence and Frequency: indicated that the resident displayed wandering behavior daily. Section E1000 Wandering - Impact: indicated that the resident's wandering significantly intruded on the privacy of activities of others. Review of physician's order dated May 24, 2024, revealed an order for Risperdal (risperidone) tablet; 0.5 mg (an antipsychotic medication used to treat certain mental/mood disorders). Special instruction included to document behaviors daily, twice a day at 9:00 AM and 5:00 PM. Review of the Medication Administration Record for daily behavioral tracking for June 2024 and July 2024, revealed no documented evidence that Risperdal was causing adverse side effects. Review of nurses' and life enrichment notes dated from June 4, 2024, though July 30, 2024, revealed Resident B1 exhibited wandering behaviors throughout the facility, picking up objects (such as wet floor signs) and carrying them around. He required constant redirection, which was not always successful. It was noted that he could become aggressive towards staff. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A nurses note dated June 17, 2024, at 4:29 PM revealed that the resident was ambulating around the facility but was leaning forward which was not his norm. MD notified and ordered a spinal X-ray. A nurses note dated June 18, 2024 at 12:04 AM revealed the resident was ambulating in the hallway partially hunched over and drooling . A wheelchair was provided and a therapy referral was sent due to the resident's need for wheelchair use. Nurses note dated June 18, 2024 at 2:26 PM revealed the resident was seated in the wheelchair with not much walking today. A nurse practitioner note dated June 20, 2024, revealed a reassessment was conducted due to staff's reports of the resident's new increased confusion and being slouched over in his chair. New orders for a urinalysis (UA), culture and sensitivity, urology consult and CT scan of the head. A nurses note dated July 4, 2024, at 4:54 PM revealed the UA results were negative. A social service note dated July 11, 2024 at 6:25 PM revealed the IDT team met to discuss how Resident B1 was doing on Risperdal. It was determined he was doing well. He remained on 15-minute checks for behavior monitoring . He continued to wander hallways. Social Worker spoke to guardian about locked secure units. A nurses note dated July 13, 2024, at 1:09 AM revealed the resident had a fall in B Hall. No injuries were noted. A nurses note dated July 13, 2024 at 7:15 PM revealed the resident had another fall on C hall. No injuries were noted. A nurses note dated July 16, 2024 at 1:38 PM revealed an order from the MD (physician) for STAT (immediate) urine test. A nurses note dated July 17, 2024, at 10:00 AM revealed that the lab called the facility and informed them that the resident's urine sample could not be processed because the urine was in in a vial and not a specimen cup. CRNP (certified registered nurse practitioner) gave a new order for the urine to be collected via a straight catheter for a drug screen and Benadryl level. A nurses note dated July 17, 2024, at 3:16 PM revealed the resident was up walking around, leaned over at times, and was able to sit in wheelchair for some time. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A CRNP progress note dated July 26, 2024, revealed that the urine drug screen was ordered on July 16, 2024, due to staff's reports of the resident drooling and being hunched over. The specimen was collected on July 16, 2024, but not processed due to it being in the incorrect specimen container. Resident with a face-to-face assessment on July 17, 2024, and noted to be drooling, hunched over, and slower to respond than normal. He had falls on July 12, 2024, and July 13, 2024. A urine drug screen and Benadryl level was ordered. Results of drug screen were received today and his urine was positive for diphenhydramine (Benadryl) for which he is not prescribed and was not previously prescribed. The CRNP discussed the findings with the facility leadership. Spoke with lab-Benadryl level still being processed and will be provided once available. Resident observed earlier today- he is ambulating ad lib (freely) around the facility upright without an assistive device. No drooling observed. The urine was negative for amphetamine, barbiturate, [NAME], THC, cocaine, meth, opiates, pcp, ethanol. ID screen positive for acetaminophen, risperidone, citalopram, diphenhydramine. He is on Tylenol, and risperidone. He had been on escitalopram which was discontinued on July 10, 2024. As above, he had not been ordered Benadryl or any medication containing the same. Review of the urine results labeled Reference Tests dated as verified July 29, 2024, revealed concentrations of diphenhydramine between [PHONE NUMBER] ng/ml were found in the urine. Review of an email communication from the CRNP to the Nursing Home Administrator dated July 29, 2024 at 11:39 AM revealed the following was communicated In June, XXX (Resident B1) was noted to have increased confusion, drooling, hunched over, using a wheelchair. Symptoms were not consistent but intermittent. Staff concerned that it may have been risperidone causing symptoms- he had been on risperidone and would expect that if he had symptoms from antipsychotic, it would be consistent. Labs and urine were done. Miraculously he didn't have any symptoms like this for several weeks. On 7/16/24, I was informed by staff that he was off again and something was not right. I ordered urine drug screen. Unfortunately, specimen was in wrong container and not processed. On 7/17/24, I was in facility and went to see resident. He was drooling, sitting in wheelchair, and extremely slow to respond to me. He was also noted to have 2 recent falls. There was no specific neurological deficit, but he seemed off from his baseline. Because it's intermittent, I was concerned that he may have drugs in his system that he shouldn't have, I ordered a drug screen including Benadryl level. Over my career, I have hard numerous horror stories of elderly residents being given Benadryl without orders. I ordered test to rule out any other reason for his intermittent increased confusion and intermittent functional decline. Signed by the CRNP According to the Merck Manual (comprehensive medical reference guide), diphenhydramine (Benadryl) is used for the prevention and treatment of allergic or hypersensitivity reactions. It is also used for treating symptoms associated with allergic rhinitis or the common cold and for cough caused by minor throat and bronchial irritation. Adverse reactions, or side effects, of this medication are asthenia (weakness or lack of energy), confusion, dizziness, drowsiness, fatigue, headache, and psychomotor impairment (slowing down of thoughts and physical movements). Interview with Employee 1 (licensed practical nurse) and Employee 2 (licensed practical nurses) on August 1, 2024 revealed Resident B1 consistently exhibited behaviors of being up all day and up all night. They reported that he is constantly wandering the hallways and does laps around the facility. They stated that he does not have family who visits or anyone who might bring him drugs or items from outside the facility. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's care plan for the problem of behavioral symptoms dated April 14, 2024, identified that the resident has physical behavioral symptoms toward others (e.g. hitting, kicking, pushing, scratching, abusing others sexually). The identified goal was that the resident will not harm others secondary to physically abusive behavior. The care plan interventions included paired care for safety, assess whether the behavior endangers the resident and/or others, avoid power struggles with resident, maintain a calm environment and approach, obtain psych consult/psychosocial therapy as needed, offer one step verbal directions for tasks, allow extra time to process information and provide consistent staff as much as possible. Continued review identified another problem category, dated May 17, 2024, of Cognitive loss/Dementia indicating that the resident was at risk for elopement, dementia, and wandering. The identified goal was that the resident will not leave the facility/building unattended. Interventions included use of a wander guard (bracelet worn that triggers an alarm when approaching doors), calmly redirect from exit doors by offering toileting and reminder of mealtimes, medications as ordered, and notify physician and responsible party of exiting behavior. The resident's care plan did not include the use of the administration of Benadryl or any medications containing diphenhydramine. At the time of the survey ending August 1, 2024, there was no documented evidence of a physician order for the administration of Benadryl to Resident B1. Interview with the Nursing Home Administrator (NHA) on August 1, 2024, verified that Resident B1 did not have a physician's order for Benadryl but received the drug during his stay at the facility. She confirmed that during the period of time when diphenhydramine showed up in his urine results, the resident appeared more sedated, and was not exhibiting his usual behavioral symptoms. The facility's follow up to the lab results concluded that a staff member in the facility had given the resident Benadryl to most readily control the resident's behaviors for staff convenience, but the perpetrator was not identified as of the time of the survey ending August 1, 2024. 28 Pa. Code 211.12(c)(d)(1)(5) Nursing Services 28 Pa. Code 211.9(a)(1)(d) Pharmacy services