STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395554	A. Building B. Wing	08/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Forest City Nursing and Rehab Center	915 Delaware Street Forest City, PA 18421

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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 interviews, it was determined that the facility failed to develop and implement a person-centered baseline care plan that incorporated individualized interventions for wound management for one resident out of five sampled (Resident 1). Findings include: A review of the clinical record revealed Resident 1 was admitted to the facility on [DATE], with diagnoses to include heart failure, diabetes and morbid obesity. A review of an admission Minimum Data Set assessment (Minimum Data Set a federally mandated standardized assessment conducted at specific intervals to plan resident care) dated July 23, 2025 revealed the resident was cognitively intact with a Brief Interview for Mental Status 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 the resident to be cognitively intact) had a surgical wound upon admission to the facility and required staff assistance with activities of daily living. A review of an admission nursing assessment dated [DATE], revealed that the resident was admitted to the facility with a surgical wound to the resident's left groin measuring 5 cm (centimeters) by 2 cm by 0.3 cm. The area was described as red and irritated, with no drainage noted. Physician's orders dated July 18, 2025, directed staff to cleanse the surgical wound with normal saline solution (a sterile mixture of water and salt used to irrigate and cleanse wounds), pat dry, apply a dry 4 x 4 gauze pad over the site, and cover with an ABD dressing (a thick, highly absorbent wound dressing) twice daily, in the morning and evening. A review of the baseline care plan, dated July 17, 2025, addressed the resident's potential for pressure sore development related to a mobility deficit. However, there was no evidence that the baseline care plan included the resident's surgical wound or the corresponding wound care interventions as ordered by the physician. During an interview on August 7, 2025, at approximately 1:00 PM, the Director of Nursing confirmed the baseline care plan did not reflect person-centered approaches specific to the resident's left groin surgical wound and that the physician-ordered wound care was not incorporated into the care plan. cross refer F684 28 Pa. Code 211.12 (d)(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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0684 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 clinical record review, physician order review, nursing documentation review, wound care consultation notes, diagnostic testing, and staff interview, it was determined the facility failed to ensure care and treatment was provided in accordance with professional standards of practice and physician orders for one of five sampled residents (Resident 1). Findings include: A review of the clinical record revealed Resident 1 was admitted to the facility on [DATE], with diagnoses to include heart failure, diabetes and morbid obesity and a recent vascular surgery to the left groin (a surgical procedure performed in the upper thigh where the leg meets the body, involving the large blood vessels that carry blood to and from the leg, done to repair or improve blood flow that may have been narrowed, blocked, or damaged). A review of the admission Minimum Data Set (MDS) dated [DATE], revealed the resident to be cognitively intact with a BIMS (Brief Interview for Mental Status) score of 15. A score of 13-15 indicates the resident is cognitively intact, meaning able to understand and make decisions about care. The assessment documented that the resident was admitted with a surgical wound and required staff assistance with activities of daily living. A nursing admission assessment dated [DATE], documented a surgical wound in the left groin measuring 5 cm x 2 cm x 0.3 cm, with the area noted as red and irritated. No drainage was documented at that time. Physician's admission orders dated July 18, 2025, directed staff to cleanse the left groin surgical wound with normal saline (a sterile saltwater solution commonly used for wound cleansing), pat dry, apply a dry 4x4 gauze pad, and cover with an ABD dressing (a thick, absorbent wound dressing) twice daily, morning and evening. A review of the resident's July 2025 Treatment Administration Record (TAR) revealed the above physician-ordered wound treatment was not transcribed onto the TAR. Physician progress notes dated July 20, 2025, documented that the surgical wound site had a reddish discharge. Vascular surgery, who evaluated the wound during the resident's hospital stay prior to admission, had determined the wound was not infected and ordered a dry dressing. Nursing documentation dated July 19, 2025, at 11:20 a.m., revealed the left groin surgical wound measured 4 cm x 1.5 cm with a large amount of serosanguineous drainage (a mixture of blood and clear yellow fluid commonly seen in wounds). The nurses' note stated the wound treatment was completed, with a large amount of drainage noted on the old dressing. The next available nursing documentation regarding wound care was July 22, 2025, at 1:59 a.m., stating the dressing was applied with moderate serosanguineous drainage and no signs of infection. Another nurses' note dated July 24, 2025, at 1:09 p.m., indicated the dressing was changed as ordered and the resident tolerated it well. A contracted wound care nurse practitioner assessment dated [DATE], documented that the wound now measured 1.5 cm x 1.7 cm x 4 cm deep, classified as an open, full-thickness wound. The wound bed was described as containing 30% granulation tissue (healthy red tissue that promotes healing) and 60% slough (dead tissue appearing white or yellow). The wound was draining a moderate amount of seropurulent drainage (a mixture of clear and pus-like drainage, suggesting possible infection). The wound treatment plan was updated to include cleansing with normal saline, application of Santyl (an enzymatic debriding agent used to remove dead tissue), packing with iodoform gauze (a sterile medicated gauze used for deep wounds), and covering with a 4x4 gauze and ABD pad. An ultrasound study (noninvasive imaging test that shows structures inside the body using high-intensity sound waves) of the left groin completed on July 24, 2025, revealed a fluid collection measuring 5.2 cm x 2 cm x 1.5 cm, consistent with either an abscess (a localized collection of pus due to infection) or hematoma (a localized collection of blood). The physician was notified, and an order was obtained for immediate follow-up with vascular surgery. Resident 1 was sent to the vascular surgeon on July 24, 2025, and admitted to the hospital for further treatment of the surgical wound. An interview with the Director of Nursing (DON) on August 7, 2025, at approximately 11:00 a.m., confirmed that the admission physician order for the left groin wound treatment had been entered into the physician's order section of the chart but was never transcribed onto the electronic treatment administration record. The DON stated that because the order was not transcribed, it could not be verified that the physician-ordered wound treatments were completed twice daily as prescribed. 28 Pa. Code 211.12(d)(3)(5) Nursing Services