Printed: 06/27/2024
Form Approved OMB
No. 0938-0391

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	03/22/2024

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39929 Based on review of select facility policy and interviews with residents and staff, it was determined that the facility failed to review the continued appropriateness and revise the resident's plan of care in response to a significant weight loss for one resident out 18 residents (Resident 18). Findings include: Review of the clinical record of Resident 18 revealed admission to the facility on [DATE], with diagnoses to include diabetes. Review of Resident 18's clinical record, conducted during the survey ending March 22, 2024, revealed that the resident had a significant weight loss identified in February 2024 and March 2024, which was addressed in nutritional progress notes with supportive interventions at the time of the identified weight losses. A review of Resident 18's care plan, dated as last revised by the facility on March 19, 2024, revealed the problem that the Resident may be nutritionally at risk related to dx of DM2 and therapeutic diet order. The resident's care plan, as of March 22, 2024, had not been updated to reflect the resident's significant weight loss, current planned interventions and the plan to monitor and prevent further decline in the resident's nutritional parameters. The facility failed to update the resident's care plan to reflect Resident 18's actual significant weight loss and need to continued monitoring of the resident's weight and nutritional parameters. Interview on March 24, 2024, at 2:30 p.m. the Nursing Home Administrator (NHA) confirmed that Resident 19's care plan was not revised after the resident experienced a significant weight loss.

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41460 Based on a review of clinical records and select investigation reports and staff interview, it was determined that the facility failed to implement effective fall prevention interventions including timely and necessary staff supervision of resident with a history of falls and known unsafe behaviors that increased the resident's risk for falls, to prevent a fall with serious injury, a fractured wrist, for one resident out of 18 sampled (Resident 49). Findings include: Clinical record review revealed that Resident 49 was admitted to the facility on [DATE], with diagnoses to include dementia, chronic kidney disease, and history of urinary tract infections. A Quarterly Minimum Data Assessment (MDS - a federally mandated standardized assessment conducted at specific intervals to plan resident care) dated April 24, 2023, indicated that Resident 49 was severely cognitively impaired with a BIMS score of 0 and required extensive assistance from two staff members for toileting and transfers and limited assistance of one staff member for ambulation in the resident's room and corridors. The resident was noted to be unsteady while walking and only able to stabilize with staff assistance according to the MDS. The resident's care plan, initially dated February 3, 2020, indicated that the resident had the potential for falls, with history of falls, related to wandering without purpose, not knowing physical limitations, impulsivity and/or poor safety awareness. Planned interventions, to reduce potential for falls, included the resident's bed in lowest position, call bell within reach, ensure resident is wearing proper footwear, monitor toileting needs, motion sensor alarm while in bed, non-skid strips to floor in front of dresser, offer bedrest in the evening after dinner, offer diversional activities when restless (music, snack, walk), place belongings within reach, pull tab alarm to bed and chair. A facility investigative report dated July 20, 2023, revealed that at 8:20 PM, Employee 2, registered nurse, was called to the first floor to evaluate Resident 49 after a witnessed fall. According to the incident description, staff observed the resident to be restless and nursing was unable to redirect the resident from the start of the 3 PM to 11 PM. The resident was in chair at nursing station for staff observation when the resident's chair alarm sounded as the resident refused to sit and wanted to ambulate. The resident fell to the floor and hit the back of head. The resident was transported to the emergency room for an evaluation after she began to vomit at the facility. The resident returned to the facility without evidence of fracture or injury. Interventions planned for implementation was to encourage the resident to take rest periods after supper, although the resident fell during a period of restless behavior, refusing to sit and displaying a desire to ambulate. A review of witness statement dated July 20, 2023, revealed that Employee 3, a nurse aide, heard an alarm while exiting another resident's room and observed Resident 49 standing at the end of the hallway. The resident turned around while holding onto the railing and when staff asked the resident to sit down, the resident lost her balance and fell backwards hitting her head on the floor. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A facility investigation report dated August 10, 2023, at 8:40 PM revealed that Resident 49 had another fall while at the nurses station, which on this occasion was noted as unwitnessed. According to the incident description, the resident was in her wheelchair at the nurse's station prior to the fall. The resident was assessed with apparent injury to right wrist and was sent to the emergency room for evaluation and was diagnosed with a fractured wrist. The resident returned to the facility with a splint and sling in place, and orders to follow-up with orthopedics in one week. The planned intervention implemented after this fall was to change the resident's chair alarm, from a clip alarm to pressure sensor alarm. Additionally, the resident's seating was evaluated with a change from standard wheelchair to a Broda chair. Prior to each fall, the witnessed fall on July 20, 2023, and the unwitnessed fall on August 10, 2023, the resident had been placed at the nurse's station for staff observation. Review of witness statement dated August 10, 2023, completed by Employee 4, nurse aide, revealed that when she came down to the first floor at 8:40 PM, came off the elevator and found the resident on the floor. Employee 4 further added on August 11, 2023, at 10 AM, indicated that it appeared that the resident had removed the clip alarm prior to attempting to stand. Review of witness statement dated August 10, 2023, completed by Employee 5, licensed practical nurse, revealed that the resident was last seen by Employee 3 sitting peacefully in the hall conversing with a peer at approximately 8:30 PM with alarm in place. Review of witness statement dated August 10, 2023, completed by Employee 3, nurse aide, revealed that at 6 PM {after dinner} she took the resident to the bathroom and got her ready for bed. At 7 PM and 8 PM Employee 3 offered the resident toileting and the resident refused. Employee 3 indicated that the employee last saw the resident seated in her chair in the hall talking to another resident, her alarm was in place and working. Review of resident's clinical record completed during survey ending March 22, 2024, revealed no documented evidence that the nursing staff had offered the resident to take a rest after dinner, which was the intervention planned after the resident's fall on July 20, 2023. Employee 3 noted the resident's activities that evening from 6 PM after dinner through the time of the fall in her statement, which did not include offering bedrest. There was also no evidence that the facility had maintained necessary supervision of the resident, who was known to display unsafe behaviors, including unassisted transfers and ambulation. Review of Resident 49's Kardex on March 21, 2024, revealed that safety interventions included in this resident's plan of care included all interventions identified on the resident's care plan, including to offer bedrest in the evening after dinner (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Interview with the Nursing Home Administrator on March 21, 2024, at approximately 1PM confirmed that there was no specific documentation that the nursing staff had offered the resident rest period after dinner prior to the resident's fall on August 10, 2023. According to the NHA, the nursing staff acknowledge completion of the planned interventions by clicking yes in the electronic record that care was provided according to Kardex including skin prevention and safety measures. This documentation is completed on each shift. During an interview on March 22, 2024, at approximately 1 PM the Nursing Home Administrator was unable to provide evidence that the facility provided effective safety and fall prevention measures, including sufficient staff supervision, to prevent this resident's fall with fracture. 28 Pa. Code 211.12 (d)(5) Nursing services

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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** 41460 Based on a review of clinical records, select facility policy and investigative reports and staff interviews it was determined that the facility failed to assess and implement individualized measures to meet the toileting needs of one resident (Resident 70) and failed to evaluate the clinical necessity of an indwelling urinary catheter for of one resident (Resident 49)out of 18 sampled. Findings included: A review of a facility policy entitled Continence Management Bladder and Bowel Continence Policy that was last reviewed by the facility on April 18, 2023, indicated that the facility will make efforts for each resident to maintain their highest practical level of bowel and bladder function. Residents that are continent will remain continent and given the opportunity to improve continence through a retraining program. A Bowel and Bladder diary will be completed for a minimum of three days to evaluate current continence status and a program will be initiated based on established toileting times from the diary. The results of the program will be documented in the resident's plan of care. A review of Resident 70's clinical record revealed that the resident was admitted to the facility on [DATE], with diagnoses that included overactive bladder [is a bladder control problem which leads to a sudden urge to urinate], urinary tract infection [(UTI) is common in older adults, mainly due to several age-related risk factors such as malnutrition, inadequately controlled diabetes mellitus, poor bladder control leading to urinary retention or incontinence, constipation, long-term hospitalization s, vaginal atrophy, prostate hyperplasia, unhygienic living conditions, and altered mental state], Alzheimer's disease [is a type of brain disorder that causes problems with memory, thinking and behavior and is a gradually progressive condition]. A review of the resident's plan of care, initiated March 6, 2024, indicated that the resident had functional bladder incontinence related to active infections with symptoms of UTI, overactive bladder, activity intolerance, Alzheimer's, confusion, and impaired mobility. Planned interventions included to establish voiding patterns with changes in continence and a prompted bladder toileting program at specific times to assess the effects of timed voiding for the management of urinary incontinence in adults who cannot participate in independent toileting. A review of the resident's admission Comprehensive Bladder and Bowel Evaluation - V 2 that was initiated on March 9, 2024, and completed on March 13, 2024, revealed that the resident was assessed to be placed on a timed prompted toileting program. Resident 70's clinical record, when reviewed during the survey ending March 22, 2024, failed to reveal that the facility had implemented the timed prompted toileting program as noted on the bladder and bowel evaluation dated March 13, 2024. During an interview with the Director of Nursing (DON) on March 20, 2024, at 1:00 p.m., the DON confirmed that the facility was unable to provide documented evidence that Resident 70's timed prompted toileting program was implemented or completed. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a facility policy entitled Urinary Continence - Clinical Protocol reviewed April 18, 2023, indicated that, as part of the initial assessment, the physician will help identify individuals with impaired urinary continence; i.e., reduced ability to maintain urine in a socially appropriate manner. For example, review of a hospital discharge summary may reveal that the individual was incontinent with or without catheter placement during a recent hospitalization , or a previous urology evaluation may have identified bladder outlet obstruction. the purpose of urinary catheterization is to facilitate urinary drainage when medically necessary. The physician will identify and refer, as appropriate, individuals who might benefit from urological procedures to address retention or improve continence. Additionally, the physician will identify and document clinically pertinent reasons why an indwelling urethral or suprapubic catheter is indicated, and will document why other alternatives are not feasible. Urinary catheters should be evaluated every day for the need and removed promptly when no longer necessary. Clinical record review revealed that Resident 49 was admitted to the facility on [DATE], with diagnoses to include dementia, chronic kidney disease, and history of urinary tract infections. Review of quarterly Minimum Data Set (MDS) assessment dated [DATE], indicated that Resident 49 was severely cognitively impaired, required extensive assistance from two staff members for toileting and transfers, was occasionally incontinent of urine, and was on a toileting program. On December 10, 2023, a physician order was noted to obtain a urinary specimen via straight catheterization due to suspected contamination of previous specimen. Nursing noted on December 12, 2023, that the urine culture and sensitivity results were pending, and a physician order was received to insert an indwelling urinary catheter with urology follow-up. Review of Indwelling Catheter Evaluation dated December 13, 2023, revealed that the resident was not admitted from acute care with the indwelling catheter in place, the reason for insertion was due to urinary retention with chronic UTI [urinary tract infection] with urology follow-up. The evaluation revealed that the following tests were not completed to confirm the presence of urinary retention: evaluation of Post Void Residual (PVR- amount of urine remaining in bladder after urination) or intermittent catheterization. There was no plan to remove the indwelling catheter noted at that time. Review of Resident 49's clinical record, during the survey ending March 22, 2024, revealed no evidence the resident was evaluated by urology after indwelling urinary catheter placement on December 12, 2023. Interview with Employee 1, licensed practical nurse, on March 22, 2024, at 9:56 a.m. confirmed that there was no evidence that Resident 49 was seen by urology since placement of the indwelling urinary catheter in December 2023. Employee 1, further confirmed that there was no urology appointment scheduled/pending at this time. The Director of Nursing confirmed during interview on March 22, 2024, that there was no physician documentation to clinically support the use of the indwelling Foley catheter for Resident 49. The DON further confirmed that there was no evidence the resident was evaluated by urology as noted in the catheter evaluation dated December 13, 2023. 28 Pa. Code 211.12 (d)(3)(5) Nursing services (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	28 Pa. Code 211.10 (a)(c)(d) Resident care policies

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26142 Based on review clinical records and staff interviews, it was determined that the facility failed to ensure that a resident was free from unnecessary psychoactive drugs by failing to assure the presence of the documented prescriber clinical rationale for the use of a psychotropic medication and justification for the use of duplicate drug therapy for dementia with psychosis for one of five residents reviewed (Resident 11). Findings include: Review of Resident 11's clinical record revealed that the resident was admitted to the facility on [DATE], with diagnoses including dementia and psychosis. A review of a a quarterly MDS (Minimum Data Set - a federally mandated standardized assessment conducted at specific intervals to plan resident care) dated December 3, 2023 revealed a BIMS score (Brief Interview for Mental Status is a mandatory tool used to screen and identify the cognitive condition of residents upon admission into a long-term care facility) of 2, indicating severe cognitive impairment. A physician orders was noted May 26, 2023, for the antipsychotic drug Seroquel 25 mg, one by mouth twice a day for dementia with psychosis. A review of medication administration records (MAR) dated May 2023 through February 12, 2024, revealed that the resident received the Seroquel 25 mg BID as ordered during that time frame. A physician order was noted February 12, 2024, the Seroquel order was changed to Seroquel 25 mg every AM and Seroquel 12.5 mg at bedtime. A supportive care behavioral health note dated February 12, 2024, at 10:01 AM revealed, Nurse Practioner (NP) in to see resident with new recommendations to decrease Seroquel to 12.5 mg PO in the morning and continue Seroquel 25 mg PO at HS. Nursing notes dated between February 2024 through March 11, 2024, revealed that the resident had displayed an increase in behavioral symptoms. A behavioral health note dated March 8, 2024, Resident continues presenting intermittent behaviors. She is confused and disorganized, delusional but not hallucinations. Her moods are labile and hard to control. She was sedated with Seroquel 25 mg twice a day for which the morning dose was decreased, but then her behaviors returned. A change in antipsychotics will be attempted. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Behavior Note dated March 9, 2024 at 5:11 PM revealed Resident agitated this evening before dinner, observed walking in hallway without walker, this nurse attempted to calm resident down, resident became verbally and physically aggressive towards me. Pinching and pushing me away. Resident continued to ambulate towards her room, nurse aide and this nurse close by with geri chair follow. Resident continued to be upset with staff yelling at us and not allowing us to assist her in any way. Once safe in her room seated, we exited. This nurse offered dinner tray to resident, she then picked up the lid and threw it at this nurse. I once again exited her room to give her some time to cool down. Will continue to check on resident to make sure she is safe. A review of a supportive care behavioral health dated March 11, 2024, at 11:53 A. M. revealed Resident was seen by the NP with new recommendations to discontinue Seroquel 25 mg PO at bedtime. Start Risperdal 0. 5 mg (antipsychotic) PO at HS. There was no documented evidence from the prescriber practitioner of the clinical necessity for the concurrent use of two antipsychotic medications to treat the resident's dementia with psychosis, which was confirmed during interview with the Director of Nursing on March 21, 2024, at approximately 1 PM. 28 Pa. Code 211.9 (a)(1) Pharmacy services 28 Pa. Code 211.5 (f) Medical records 28 Pa. Code 211.2 (d)(3) Medical director