

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395567	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/29/2024
NAME OF PROVIDER OR SUPPLIER Dunmore Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1000 Mill Street Dunmore, PA 18512	

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)
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21738</p> <p>Based on review of select reports, facility policy, and clinical records, and staff interviews it was determined that the facility failed to provide nursing services consistent with professional standards of quality by failing to demonstrate that licensed nurses thoroughly assessed and consistently monitored a resident after the resident ingested a potentially harmful substance for one resident out of eight sampled (Resident A1).</p> <p>Findings included:</p> <p>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 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.</p> <p>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 judgement 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.</p> <p>According to the American Nurses Association Principles for Nursing Documentation, nurses document their work and outcomes and provide an integrated, real-time method of informing the health care team about the patient status. Timely documentation of the following types of information should be made and maintained in a patient's EHR (electronic health record) to support the ability of the health care team to ensure informed decisions and high-quality care in the continuity of patient care:</p> <p>Assessments</p> <p>Clinical problems</p> <p>Communications with other health care professionals regarding the patient</p> <p>Communication with and education of the patient, family, and the patient's designated support person and other third parties.</p> <p>(continued on next page)</p>

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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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of the undated facility policy titled Resident Change in Condition indicated that the nurse will address any emergency care required given the situation and then gather information prior to contacting the physician that include current vital signs, when the condition occurred, background and the situation. Changes in condition will be included on 24-hour report and communicated in morning meeting.</p> <p>A review of clinical record revealed that Resident A1 was admitted to the facility on [DATE], with diagnoses to include encephalopathy (disease that affects the brain structure or function and causes altered mental status), and type 2 diabetes mellitus (a condition resulting in insufficient production of insulin causing high blood sugar).</p> <p>A quarterly Minimum Data Set assessment (MDS - a federally mandated standardized assessment process conducted at specific intervals to plan resident care) dated March 13, 2024, revealed that the resident was severely cognitively impaired.</p> <p>A facility report dated May 12, 2024, at 5:42 PM revealed that Resident A1's family saw him drink a liquid that was at the resident's bedside which was later identified as Betadine 10% solution approximately 10 milliliters (ml) left behind by the nurse after a heel dressing change (Betadine is used on the skin to treat or prevent skin infection in minor cuts, scrapes, or burns, Betadine should not be used in the mouth if you are using a form that is made for use only on the skin, and should not be swallowed). The resident thought it was liquid protein solution. The on-call physician and poison control were notified.</p> <p>A progress note dated May 12, 2024, at 6:46 PM revealed that poison control suggested feeding the resident a carbohydrate, probably a loaf of bread, and watch out for any vomiting; and to call back if this occurs. The resident was reassured and had already eaten a sandwich for dinner, no incidents noted.</p> <p>A facility report dated May 13, 2024, at 1:30 PM revealed that the betadine treatment the nurse provided to the resident's heel on May 12, 2024, was performed at nursing judgement, as the resident had no physician order for this treatment. An in-service education was conducted with staff informing them not to apply treatments without a physician order and do not leave treatments/personal care items at the bedside; they must be put away.</p> <p>However, following the resident's ingestion of the betadine on May 12, 2024, there was no documented evidence that licensed and professional nursing staff had consistently monitored and timely assessed the resident for any changes in condition from the time the resident ingested a potentially harmful substance until the following day May 13, 2024 at 9:17 AM.</p> <p>A review of Observation Detail List Report revealed a focused head to toe observation performed by a Registered Nurse (RN) of the resident post ingestion of betadine solution.</p> <p>Interview with the Director of Nursing (DON) on May 29, 2024, at approximately 9:30 AM revealed that she was not aware of the incident on May 12, 2024, until the following day when she noticed documentation in the resident's clinical record stating that the resident had swallowed betadine solution.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview with the DON and Nursing Home Administrator (NHA) on May 29, 2024, at approximately 2:35 PM confirmed there was no documented evidence in the resident's clinical record that the facility's licensed and professional nursing staff had fully assessed and consistently monitored Resident A1 after swallowing a potentially harmful substance.</p> <p>Refer F689</p> <p>28 Pa. Code 211.12 (c)(d)(1)(3)(5) Nursing Services</p> <p>28 Pa. Code 211.5 (f) Medical Records</p>

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21738</p> <p>Based on observation, a review of select facility policy, clinical records, and select incident/accident reports and staff interview, it was determined that the facility failed to maintain an environment free of potential accident hazards to prevent accidental ingestion and misuse of substances not intended for oral use and to prevent access to resident personal care supplies, treatment products, and medications that may be mishandled or consumed by residents for whom the medications were not prescribed, for two residents out of eight sampled (Resident A1 and A2) and observed on two of two nursing units.</p> <p>Findings include:</p> <p>A review of an undated facility policy titled General Dose Preparation and Medication Administration indicated that facility staff should not leave medications or chemicals unattended. Facility staff should enter the date opened on the label of the medication with shortened expiration dates for example insulins and irrigation solutions.</p> <p>A review of an undated facility policy titled Storage and Expiration Dating of Medications and Biologicals indicated the facility should ensure that all medications and biologicals including treatment items are securely stored in a locked cabinet/cart or locked medication room that is inaccessible by residents and visitors. Topical external use medications or other medications should be stored separately from oral medications. Medication packaging should have a label with an expiration date once the package is opened the facility should follow supplier guidelines with respect to expiration dates and staff should record the date opened on the primary medication bottle when it has a shortened expiration date.</p> <p>A review of clinical record revealed that Resident A1 was admitted to the facility on [DATE], with diagnoses to include encephalopathy (disease that affects the brain structure or function and causes altered mental status), and type 2 diabetes mellitus (a condition resulting in insufficient production of insulin causing high blood sugar).</p> <p>A quarterly Minimum Data Set assessment (MDS - a federally mandated standardized assessment process conducted at specific intervals to plan resident care) dated March 13, 2024, revealed that the resident was severely cognitively impaired.</p> <p>A facility report dated May 12, 2024, at 5:42 PM revealed that Resident A1's family saw him drink a liquid that was at the resident's bedside which was later identified as Betadine 10% solution approximately 10 milliliters (ml) left behind by the nurse after a heel dressing change (Betadine is used on the skin to treat or prevent skin infection in minor cuts, scrapes, or burns, Betadine should not be used in the mouth if you are using a form that is made for use only on the skin, and should not be swallowed). The resident thought it was liquid protein solution. The on-call physician and poison control were notified.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A progress note dated May 12, 2024, at 6:46 PM revealed that poison control suggested feeding the resident a carbohydrate, probably a loaf of bread, and watch out for any vomiting; and to call back if this occurs. The resident was reassured and had already eaten a sandwich for dinner, no incidents noted.</p> <p>A facility report dated May 13, 2024, at 1:30 PM revealed that the betadine treatment the nurse provided to the resident's heel on May 12, 2024, was performed at nursing judgement, as the resident had no physician order for this treatment. An in-service education was conducted with staff informing them not to apply treatments without a physician order and do not leave treatments/personal care items at the bedside; they must be put away.</p> <p>A review of an employee witness statement dated May 16, 2024, (no time) revealed that Employee 1, Licensed Practical Nurse (LPN) was notified that the resident wanted his heels wrapped. After realizing there was not a physician order for this treatment Employee 1 noted that I asked Employee 2 Registered Nurse Supervisor (RNS) if it was okay to wrap his heels without an order and she said it was fine. The resident asked if I could apply betadine, I poured 10 mls of betadine into a medication cup and went to do the treatment. After completion I cleaned up and left, the room. Staff then notified me that family observed the resident drink the brown liquid in the medication cup, this was reported to Employee 2 RNS immediately who called the physician and poison control. Employee 2 RNS advised me to monitor the resident for vomiting and to encourage food and fluids.</p> <p>A review of Ad Hoc QAPI/QAA Form dated May 16, 2024, (no time) revealed the problems of potential hazardous solution left at the bedside and treatment completed without an order. A facility sweep, interviews and skin assessment was completed after the incident and any identified issues were removed.</p> <p>An observation conducted during a tour of resident rooms on May 29, 2024, at 9:26 AM revealed a barrier cream and a bottle of Acetic Acid (antiseptic agent not used for consumption) irrigation solution opened, without an expiration date, and unattended on a bedside table in resident room [ROOM NUMBER].</p> <p>An observation on May 29, 2024, at 9:35 AM revealed a bottle of shaving cream and normal saline solution ([NSS] used as a topical cleansing agent) opened, without an expiration date and unattended on a dresser in resident room [ROOM NUMBER].</p> <p>An observation on May 29, 2024, at 10:00 AM revealed a four ounce bottle of sterile water and irrigation kit on a dresser in resident room [ROOM NUMBER]-W.</p> <p>Interview with the Director of Nursing (DON) on May 29, 2024, at approximately 10:15AM confirmed that treatments and personal care items were not to be left at the bedside. The DON confirmed that the facility failed to maintain the residents' environment free of potential accident hazards by leaving treatments and personal care items accessible to residents, which may allow accidental consumption or misuse.</p> <p>A review of clinical records revealed that Resident A2 was admitted to the facility on [DATE], with diagnosis to include dementia (a neurocognitive disorder that affects memory, thinking and interferes with daily life) and depression (mood disorder with symptoms of sadness).</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A quarterly MDS of Resident A2 dated May 3, 2024, indicated the resident was moderately cognitively impaired.</p> <p>An observation on May 29, 2024, at 8:49 AM revealed a medication cup filled with multiple medications on Resident A2's bedside table unsupervised by staff.</p> <p>A review of Medication Administration Record for the month of May 2024, revealed that on May 29, 2024, at 9:00 AM Resident A2 was scheduled to receive the following medications by mouth:</p> <p>Duloxetine 30 milligrams (mg) (antidepressant medication)</p> <p>Oxybutynin Chloride Extended Release (ER) 5 mg (overactive bladder medication)</p> <p>Potassium Chloride ER 20 micro equivalents (MEQ) (low potassium supplement medication)</p> <p>Vitamin D2 1,250 micrograms (mcg)/50,000 units (vitamin D supplement medication)</p> <p>There was no documented evidence that the resident self-administered medications, which had been left at the resident's bedside.</p> <p>During an interview with the DON on May 29, 2024, at 2:30 PM confirmed that the resident should have been supervised while taking the observed medications and verified that Resident A2 does not self-administer medications.</p> <p>28 Pa. Code 211.10 (d) Resident care policies</p> <p>28 Pa. Code 211.12 (c)(d)(1)(5) Nursing services</p>