

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  01/24/2025
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 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 39929</p> <p>Based on review of clinical records, select resident incident report, and staff interviews it was determined the facility failed to provide nursing services consistent with professional standards of quality by failing to thoroughly conduct and document the results of a professional nursing assessment regarding the clinical status of a resident following a change in condition for one resident (Resident 1) out of 8 residents reviewed.</p> <p>Findings include:</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>A review of Resident 1's clinical record revealed an admitted to the facility December 5, 2018, with diagnoses to include aphasia (a language disorder that affects the ability to speak and understand what others say. It usually happens suddenly after a stroke or traumatic brain injury).</p> <p>A review of a quarterly Minimum Data Set assessment (MDS-a federally mandated standardized assessment process conducted at specific intervals to plan resident care) dated November 7, 2024, revealed that Resident 1 was cognitively impaired and required substantial assistance with activities of daily living.</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 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of nursing documentation dated September 10, 2024, at 7:38 p.m., revealed Resident 1's daughter expressed concern about her mother's condition to Employee 1 (LPN). Employee 1 noted the resident was clammy, and lethargic. Resident 1's vital signs were taken and her Oxygen saturation (the amount of oxygen you have circulating in your blood) was 87%. The normal range is 95 to 100%. Resident 1's daughter asked the RN supervisor on duty Employee 2, to assess her mother. The resident's nursing progress note stated that Employee 2 was present on unit to assess the resident. However, there was no documented evidence that an assessment was completed.</p> <p>Further review of the clinical record revealed no additional documentation regarding Resident 1's condition until September 11, 2024, at 9:10 a.m., when Employee 3 (RN) noted the resident's condition had not improved and contacted the physician. STAT (immediate) labs were ordered, and results returned at 11:53 a. m. indicated an elevated white blood cell count of 32.68 K/ul (thousands per microliter of blood normal adult 4.0 K/ul -11.0 K/ul or 4000-11000 cells per microliter), consistent with an active infection. However, the resident was not transferred to the hospital until 2:01 p.m. on September 11, 2024. Resident 1 was later diagnosed and treated for sepsis (a condition that arises when the body's response to infection causes injury to its own tissues and organs) returning to the facility on [DATE].</p> <p>There was no documented evidence that a thorough and timely nursing assessment was conducted following the resident's initial change in condition. Additionally, the facility failed to escalate care in a timely manner, which delayed appropriate medical intervention. The facility failed to ensure nursing services were provided consistent with professional standards.</p> <p>Interview with the Nursing Home Administrator and Director of Nursing on January 24, 2025, at 11:30 a.m. confirmed that the facility nursing staff didn't timely assess and timely send the resident to the hospital for her documented change in condition resulting in the lack of provided nursing services consistent with professional standards</p> <p>28 Pa Code 211.12 (1)(3)(5) Nursing Services</p>		