STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395567	A. Building B. Wing	06/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dunmore Health Care Center	1000 Mill Street Dunmore, PA 18512

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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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of facility policy, Resident Council meeting minutes, grievance documentation provided by the facility, and resident and staff interviews, it was determined the facility failed to make reasonable efforts to address concerns raised by the Resident Council and failed to keep residents informed regarding the status and outcome of identified concerns. The facility did not ensure ongoing communication or timely follow-up regarding issues presented by residents in resident council, and resident interviews for four of 10 residents reviewed. (Residents 2, 3, 4, 5).Findings include: A review of the facility policy titled Call Light Resident Communication Systems, last reviewed December 17, 2025, revealed it is the facility's policy to provide residents with a means of communicating with staff. The policy indicated it is the expectation of the facility staff to respond to the residents' needs and requests promptly. A review of a grievance dated April 6, 2026, revealed Resident 3 reported that at approximately 6:15 AM a nurse aide answered the resident's call bell, turned the call bell off without asking what assistance was needed, and left the room. Documentation of the facility's follow-up indicated the nurse aide received education regarding the proper response to resident call bells. A review of a grievance dated April 8, 2026, revealed Resident 4 reported that both the resident and the roommate rang their call bells for what they believed was one hour before a nurse responded. Facility documentation indicated the event occurred around the evening meal, call bell audits (reviews used to measure how quickly staff respond to residents' requests for assistance after a call bell is activated) were initiated on the 3:00 PM. to 11:00 PM shift for a duration of one week, and the grievance was documented as resolved on April 8, 2026. A review of Resident Council meeting minutes dated April 15, 2026, revealed the residents in attendance again voiced concern regarding prolonged call bell response times, and a grievance form was initiated. A review of the grievance dated April 15, 2026, revealed Resident 2 reported that on April 13, 2026, nurse aides took longer than 15 minutes to respond to the resident's call bell during the 3:00 PM to 11:00 PM shift. Documentation completed by the Nursing Home Administrator indicated call bell audits were initiated on the evening shift and second-floor staff received education regarding timely responses to call bells. The grievance was documented as resolved on April 17, 2026, based on the initiation of audits and staff education. However, a review of Resident Council meeting minutes dated May 21, 2026, revealed residents continued to report prolonged call bell response times, particularly during the 3:00 PM to 11:00 PM shift. The meeting minutes documented that call bell audits had already been initiated, indicating the previously documented corrective actions had not resolved residents' ongoing concerns. A review of Resident Council meeting minutes dated June 10, 2026, revealed residents reported call bell response times were getting better. However, the facility was unable to provide documentation demonstrating residents had been informed of the outcome of the grievances or that residents were satisfied with the facility's resolution of the concerns raised through the grievance process. A review of Resident 2's clinical record revealed the resident was admitted on [DATE], with diagnoses including weakness and altered gait and mobility (difficulty walking and moving safely). A review of Resident 2's Quarterly Minimum Data Set assessment (MDS, a federally mandated standardized assessment process (continued on next page)

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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	conducted periodically to plan resident care) dated May 5, 2026, revealed that Resident 2 was cognitively intact with a BIMS 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 through 15 indicates no cognitive impairment). The MDS revealed Resident 2 required extensive assistance with toileting hygiene, including cleansing after urination or a bowel movement. During an interview on June 23, 2026, at 9:28 a.m., Resident 2 stated staff frequently took an extended time to answer the call bell. Resident 2 reported requiring assistance while using the toilet and stated that on multiple occasions the resident waited longer than 40 minutes for assistance with toileting hygiene. Resident 2 stated the prolonged wait caused leg pain from remaining seated on the toilet. The resident reported she has experienced elongated wait times, causing her to urinate on herself due to no response to her request for assistance. A review of Resident 5's clinical record revealed the resident was admitted on [DATE], with diagnoses including a fracture of the left clavicle (collarbone) and fracture of one rib on the left side. A review of Resident 5's admission MDS dated [DATE], revealed the resident was cognitively intact with a BIMS score of 15, indicating no cognitive impairment. During an interview conducted on June 23, 2026, at 9:22 AM revealed the resident was recently admitted to the facility but required assistance to use the bathroom due to the limited mobility of his left side due to the movement restrictions of his left arm. Resident 5 reported that on the evening before the interview the resident waited for what it felt like 45 minutes after activating the call bell before staff responded. Resident 5 further stated there did not appear to be enough staff available during the evening shift and that lengthy call bell response times were common. The facility provided call bell audit records; however, the audits did not identify prolonged response times consistent with the concerns repeatedly expressed by residents. Additionally, the facility was unable to provide documentation demonstrating it interviewed residents who did not attend Resident Council meetings to determine whether call bell response times had improved after implementation of corrective actions. The facility was also unable to provide documentation demonstrating residents were informed of the status or outcome of the grievances or that residents were satisfied the concerns regarding prolonged call bell response times had been adequately resolved. During an interview on June 23, 2026, at 3:25 PM the above findings were reviewed with the Nursing Home administrator regarding the lack of resolution and outcome of grievances related to prolonged call bell response times. 28 Pa. Code 201.18 (e)(1)(4) Management. 28 Pa. Code 201.29(a) Resident Rights. 28 Pa. Code 211.10 (d) Resident care policies.

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F 0689 Level of Harm - Minimal harm or potential for 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** Based on observations, a review of clinical records, select facility policies, and staff interviews, it was determined the facility failed to securely store medications and restrict resident access to medications in accordance with facility policy for one of two nursing units (Unit 2) and one of ten residents reviewed (Resident 7), creating the potential for accident hazards.Findings included: A review of the facility policy titled Storage and Expiration Dating of Medications and Biologicals, last reviewed December 17, 2025, revealed it is the facility policy that all medications and biologicals including bedside medications or biologicals are stored in a locked compartment within the resident's room. A review of the facility policy titled Self-Administration of Medications, last reviewed December 17, 2025, revealed it is the facility policy that self-administered medications are stored in a safe and secure place, which is not accessible by other residents. If safe storage is not possible in a resident's room, the medication of residents permitted to self-administer is stored on a central medication cart or in the medication room. A clinical record review revealed Resident 7 was admitted to the facility on [DATE]. A review of a quarterly Minimum Data Set assessment (MDS, a federally mandated standardized assessment process conducted periodically to plan resident care) dated March 27, 2025, revealed that Resident 7 was cognitively intact with a BIMS 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 to 15 indicates cognition is intact). A review of the clinical record revealed no documentation that Resident 7 had been assessed or approved to safely self-administer medications. An observation conducted on June 23, 2026, at 9:15 a.m. revealed a box containing a tube of medicated hemorrhoidal ointment (a medication used to relieve itching, burning, swelling, and discomfort caused by hemorrhoids) with an applicator sitting unsecured on Resident 7's windowsill. The tube did not display resident-specific directions for use or application instructions. The manufacturer's labeling for the hemorrhoidal ointment directs that the medication is intended for rectal or external use only, should not be taken by mouth, and instructs users to seek immediate medical assistance if the product is swallowed. During an interview on June 23, 2026, at 9:15 AM, Resident 7 indicated that staff apply the ointment for him. A review of the physician's orders revealed an order dated June 3, 2026, directing staff to apply the hemorrhoidal ointment rectally up to four times daily as needed. An observation conducted on June 23, 2026, at 9:24 a.m. in room [ROOM NUMBER] revealed a tube of medicated barrier cream and a tube of Peleverus cream (topical medications commonly used to protect skin from moisture-related damage and to treat fungal skin conditions) sitting unsecured on the windowsill. Neither tube displayed resident-specific directions for use or application instructions. An observation conducted on June 23, 2026, at 9:26 a.m. in room [ROOM NUMBER] revealed a tube of medicated barrier cream and a tube of medical-grade Manuka honey (a wound treatment used to promote healing and protect damaged skin) sitting unsecured on the windowsill. Neither product displayed resident-specific directions for use or application instructions. During an interview on June 23, 2026, at 3:26PM, the above information was reviewed with the Nursing Home Administrator. The facility failed to ensure medications were stored in accordance with its policies and failed to ensure only residents who had been assessed and determined capable of safely self-administering medications had access to medications kept in resident rooms. As a result, unsecured medicated creams and ointments were accessible within resident rooms on Unit 2, creating the potential for accidental misuse, inappropriate application, ingestion, or use by unauthorized individuals. 28 Pa. Code 201.18 (b)(1) Management. 28 Pa. Code 211.10 (d) Resident care policies. 28 Pa. Code 211.12 (c)(d)(1)(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** Based on a review of clinical records, facility policy, and staff interviews, it was determined the facility failed to assess bowel and bladder function, identify residents' patterns of incontinence, and develop individualized toileting programs to restore or maintain normal bowel and bladder function to the extent possible for two of 10 residents reviewed (Residents 1 and 8).Findings include: A review of the facility policy titled Continence Management Program, last reviewed April 15, 2026, revealed that upon admission, the admitting licensed nurse is responsible for completing a head-to-toe assessment (a comprehensive physical assessment of the body from head to feet), including an interview with the resident and a review of underlying medical conditions that may affect the resident's ability to participate in a continence management program. The policy indicated that nursing staff will identify each resident who is incontinent and assess, plan, and implement appropriate treatment and services to restore or maintain as much normal urinary and bowel function as possible. The policy revealed that a continence evaluation is conducted to determine whether a 72-hour bowel and bladder tracking record is indicated to identify the resident's pattern of continence and incontinence. The licensed nurse is responsible for instructing nursing assistants to complete the tracking documentation. After a pattern has been identified, the licensed nurse is responsible for completing a new continence evaluation and developing an individualized toileting program based on the resident's identified needs. A review of Resident 1's clinical record revealed the resident was admitted to the facility on [DATE], with diagnoses which included overactive bladder and muscle weakness. A review of Resident 1's quarterly Minimum Data Set assessment (MDS. a federally mandated standardized assessment process conducted periodically to plan resident care) dated April 9, 2026, revealed the resident was completely dependent on staff for toileting, including transfers on and off the toilet and personal hygiene after toileting. The MDS documented that the resident was always incontinent of urine and had no toileting program in place. A review of the resident's care plan initially dated May 7, 2024, revealed the resident was at risk for skin breakdown due to urinary incontinence. The care plan indicated the resident had an overactive bladder and was at risk of infection. A review of Resident 1's progress notes revealed the resident had received ongoing treatment beginning August 2, 2025, for a wound to the right posterior thigh caused by moisture-associated skin damage (MASD). A review of Resident 1's wound care note dated November 12, 2025, documented the right thigh wound had resolved. A review of the clinical record revealed no documented continence evaluation, or bladder assessment was completed between November 12, 2025, and April 15, 2026. The clinical record revealed no individualized toileting program, or scheduled toileting interventions were developed to reduce urinary incontinence or prevent moisture-associated skin damage despite the resident's documented urinary incontinence and previous skin breakdown. A review of Resident 1's progress notes dated April 15, 2026, at 2:10 PM documented the resident had developed a new abrasion to the right thigh. A treatment order was obtained to apply medical-grade honey (a sterile topical wound treatment made from purified honey to used to promote healing and reduce bacteria in the wound), apply zinc oxide (a protective skin barrier cream used to shield the skin from moisture) to the surrounding skin, and cover the wound with an ABD pad (a highly absorbent dressing used to protect and absorb drainage from wounds) daily and as needed. A wound care assessment completed April 15, 2026, at 6:23 PM revealed the resident's right posterior thigh wound had reopened. The assessment documented the resident was incontinent of urine and spent prolonged periods sitting in a wheelchair, resulting in irritation that caused the wound to reopen. A wound care progress note dated May 8, 2026, at 12:21 PM documented the resident remained at risk for skin breakdown and moisture-associated skin damage due to urinary incontinence and inability to perform self-care. A review of Resident 1's clinical record revealed no documented continence evaluation, or bladder (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	assessment was completed before or after the recurrence of the moisture-associated skin damage. The clinical record revealed no individualized toileting program had been developed despite the resident's documented urinary incontinence and recurrent skin breakdown associated with prolonged moisture exposure. A review of Resident 8's clinical record revealed the resident was admitted to the facility on [DATE], with diagnoses that included status post traumatic subdural hemorrhage (bleeding between the brain and the skull following a head injury), dementia (a condition affecting memory, thinking, and decision-making), and anxiety. A review of Resident 8's admission Minimum Data Set assessment dated [DATE], revealed the resident was always incontinent of bowel and bladder. A review of the clinical record revealed no documented bowel or bladder assessment or continence evaluation was completed following the resident's admission to identify the resident's pattern of incontinence. The clinical record revealed the facility failed to assess the resident's bowel and bladder status upon admission and failed to identify the resident's continence patterns in order to develop an individualized toileting program designed to restore or maintain normal bowel and bladder function to the extent possible.A review of the Resident 8's care plan, initiated June 2, 2026, identified urinary incontinence related to urgency and the need for assistance with toileting. The only intervention directed staff to check the resident for wetness and change the resident as needed. Resident 8's care plan contained routine hygiene measures but did not include an individualized toileting schedule, continence management program, bowel or bladder retraining interventions, or interventions based on an identified pattern of incontinence. During an interview conducted on June 12, 2026, at approximately 2:15 PM the Nursing Home Administrator and Director of Nursing confirmed the facility was not completing bowel and bladder assessments to identify residents' continence patterns or develop individualized toileting programs. They confirmed the facility had not completed continence evaluations for Residents 1 and 8 as required by facility policy. 28 Pa. Code 211.10 (c)(d) Resident care policies. 28 Pa. Code 211.12(c)(d)(1)(3)(5) Nursing services.