

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  12/03/2025
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 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement policies and procedures to prevent abuse, neglect, and theft.</p> <p>Based on a review of the facility's abuse prohibition policy, employee personnel files and staff interviews, it was determined the facility failed to implement procedures to fully screen two employees out of five to ensure they were eligible for employment in a long term care nursing care facility. (Employees 1, and 2). Findings include: According to regulatory requirements under SS483.12(a)(3) and 483.12(b)(1) the facility must have written procedures for screening prospective employees, to include reviewing: the employment history (e.g., dates of employment position or title), particularly where there is a pattern of inconsistency; information from former employers, whether favorable or unfavorable; and/or documentation of status and any disciplinary actions from licensing or registration boards and other registries. A review of the facility's Resident Abuse policy last reviewed by the facility May 29, 2025, revealed the requirement for screening potential employees included obtaining references from two previous employers. Review of employee personnel files revealed the following: Employee 1 (Licensed Practical Nurse): Hired on August 06, 2025. The application listed previous employers, but there was no documentation showing the facility had contacted the most recent former employer. Employee 2 (Nurse Aide): Hired on June 17, 2025. The application listed previous employers, but there was no documentation showing the facility had contacted the most recent former employer to fully screen the individual to ensure the individual was eligible for employment in a long term care nursing facility. Interview with the Nursing Home Administrator (NHA) on October 1, 2025, at 10:15 a.m. the NHA was unable to provide evidence that previous employers were contacted for information regarding the employees past work history. The facility failed to follow its own abuse prohibition policy by not verifying previous employment for two out of five new hires. 28 Pa. Code 201.18 (e)(1) Management. 28 Pa. Code 201.29 (a)(c) Resident Rights. 28 Pa. Code 201.14(a) Responsibility of Licensee. 28 Pa. Code 201.19 (1) Personnel records.</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 - Some</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>Based on observation, review of clinical records, and resident and staff interviews it was determined the facility failed to provide services consistent with professional standards of practice by failing to implement the physician-ordered bowel management protocol and to notify the physician when ordered interventions were not effective for one resident (Resident 19) out of 21 residents reviewed. Findings include: According to the American Academy of Family Physicians (The American Academy of Family Physicians is one of the largest medical organizations in the US founded to promote the science and art of family medicine) the primary goal of constipation management should be symptom improvement, and the secondary goal should be the passage of soft, formed stool without straining at least three times per week. A review of Resident 19 ' s clinical record revealed active physician orders dated May 8, 2025, for a bowel regimen (a prescribed sequence of interventions to promote regular bowel movements and prevent constipation) as follows: Milk of Magnesia (MOM) Suspension 400 mg/5ML (Magnesium Hydroxide): Give 30 ml by mouth as needed for constipation if there is no BM (bowel movement) after the third day. Bisacodyl suppository; 10 mg: Insert 1 suppository rectally as needed for constipation if no BM on the fourth day and no result from MOM. Enema (Fleet enema-sodium phosphate enema): Insert 1 application rectally as needed for constipation if no BM on the fifth day and no result from the suppository, notify the physician if no bowel movement occurs. A review of Resident 19 ' s bowel tracking records for September 2025 revealed the resident did not have a documented bowel movement on September 18, 19, 20, 21, or 22, 2025. A review of Resident 19 ' s Medication Administration Record (MAR) for the same period revealed no documented evidence that nursing staff administered the physician-ordered Milk of Magnesia, suppository, or enema as indicated. There was also no documentation that the physician was notified after the fifth day without a bowel movement, as required by the physician ' s orders. An interview with the Director of Nursing (DON) conducted on October 1, 2025, at 11:10 AM, confirmed there was no evidence that the bowel protocol was implemented or that the physician was notified of the lack of bowel activity during the five-day period. September 18, 19, 20, 21 and 22, 2025 28 Pa. Code 211.12 (d)(1)(3)(5) Nursing services 28 Pa. Code 211.5(f)(i)(ix) Medical records</p>		

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<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate pain management for a resident who requires such services.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on clinical record review, review of select facility policies, and staff interview, it was determined the facility failed to attempt non-pharmacological interventions to alleviate pain prior to administering a narcotic pain medication prescribed on an as-needed basis for one resident (Resident 6) out of 21 sampled residents. Findings include:A review of the facility's policy entitled Pain Management Policy with a policy review date of May 29,2025, indicated that non- pharmacological interventions (methods to relieve pain that do not involve medication, such as repositioning, relaxation techniques, heat/cold therapy, or distraction) will be attempted prior to the admission of a PRN (as needed) medication, If the non-pharmacological interventions fail then when corresponding intensity ratings, the resident will be administered the medication ordered for the corresponding pain rating within the PRN order.A review of Resident 6 ' s clinical record revealed the resident was admitted to the facility on [DATE], with diagnoses including Chronic Obstructive Pulmonary Disease (COPD) (a long-term lung condition that limits airflow due to lung damage) and Neoplasm of unspecified behavior of the bladder (a bladder tumor of uncertain type).A review of Resident 6's quarterly Minimum Data Set assessment (MDS-a federally mandated standardized assessment process conducted periodically to plan resident care) dated September 17, 2025, revealed that Resident 6 was cognitively intact with a BIMS score of 13 (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 cognition is intact)A review of Resident 6 ' s clinical record revealed a physician ' s order dated January 16, 2025, revealed Acetaminophen 325 mg, administer two tablets (650 mg) by mouth every six hours as needed for pain or headache, not to exceed 3 grams in 24 hours. The order did not identify a pain intensity level (e.g., mild, moderate, or severe) or a numeric pain scale (0-10, where 0 is no pain and 10 is worst pain) and Oxycodone 5 mg (a narcotic pain medication), twice daily as needed for severe pain rated 7-10.A review of Resident 6 ' s electronic Medication Administration Record (eMAR) (a digital record used to document each resident ' s medications) for September 2025 revealed that Oxycodone 5 mg was administered without documented attempts of non-pharmacological interventions and without documentation of pain level or reassessment on the following dates and times:A review of Resident 6 ' s electronic Medication Administration Record (eMAR) (a digital record used to document each resident ' s medications) for September 2025 revealed that Oxycodone 5 mg was administered without documented attempts of non-pharmacological interventions and without documentation of pain level or reassessment on the following dates and times:September 1, 2025 - 3:51 PMSeptember 9, 2025 - 8:25 PMSeptember 15, 2025 - 3:51 PMSeptember 16, 2025 - 7:19 PMSeptember 18, 2025 - 9:58 PMSeptember 19, 2025 - 4:32 AMSeptember 22, 2025 - 2:21 PMIn each instance, there was no documentation that staff assessed Resident 6 ' s pain level before administering the medication or that any non-pharmacological interventions were attempted prior to giving the opioid.An interview was conducted with the NHA (Nursing Home Administrator) on August 15, 2025, at 9:30 AM, to review the above findings related to the facility failure to assure that licensed nursing staff attempted non-pharmacological interventions prior to administering analgesic pain medication that included opioids.in accordance with facility policy.28 Pa. Code 211.5(f)(ii)1(viii)(ix) Medical records.28 Pa. Code 211.10 (c)(d) Resident care policies. 28 Pa. Code 211.12 (c)(d)(1)(5) Nursing Services.</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>Based on a review of controlled drug shift count records, facility policies, and staff interviews, it was determined that the facility failed to ensure accurate documentation of controlled (Schedule II) medications (controlled medications are drugs regulated under the federal Controlled Substances Act due to their potential for abuse or dependence, with Schedule II drugs having a high potential for abuse but accepted medical use) by both the oncoming and off-going nurses (the licensed nurses assuming or ending responsibility for a medication cart at the change of shift) for two of two medication carts observed (First Floor [NAME] Hall and First Floor East Hall). Findings include: A review of the facility policy entitled Inventory Control of Controlled Medications, last reviewed May 29, 2025, revealed that controlled drugs (medications regulated under federal and state law due to their potential for abuse) must be inventoried and documented under proper security and in accordance with state and federal regulations. The policy further indicated that Schedule II controlled medications (drugs such as oxycodone or hydromorphone that have a high potential for abuse but legitimate medical use) are to be counted jointly by the oncoming and off-going nurses at each shift change and recorded on the narcotic shift count sheet (a document used to verify the exact number of controlled medications at the end and beginning of each shift). A review of the facility's Narcotic Logbook (a bound or electronic record used to document the receipt, administration, and shift-to-shift count of controlled drugs) for the First Floor [NAME] Hall medication cart revealed the following omissions: September 19, 2025 - the night-shift oncoming nurse failed to sign the narcotic count. September 20, 2025 - the nightshift off-going nurse failed to sign the narcotic count. September 22, 2025 - the day-shift oncoming and off-going nurses failed to sign the narcotic count. September 26, 2025 - the night-shift oncoming and off-going nurses failed to sign the narcotic count. September 28, 2025 - the evening-shift off-going nurse failed to sign the narcotic count. An interview with Employee 1 (LPN) Licensed Practical Nurse, conducted October 1, 2025, at 8:45 A. M., confirmed that the narcotic sheets were not signed by both nurses on the above dates. A review of the Narcotic Logbook for the First Floor East Hall medication cart revealed similar documentation omissions: September 15, 2025 - day-shift oncoming nurse failed to sign. September 20, 2025 - day-shift oncoming nurse, evening-shift off-going nurse (two entries), and night-shift oncoming and off-going nurses failed to sign. September 21, 2025 - night-shift oncoming and off-going nurses failed to sign. October 1, 2025 - day-shift oncoming nurse failed to sign. An interview with Employee 2 (LPN) conducted October 1, 2025, at 8:35 A.M., confirmed that the narcotic sheets were not signed off by the oncoming and off-going nurses for the above dates. An interview on October 1, 2025, at 11:00 AM, the Nursing Home Administrator verified it is the expectation of the facility staff to demonstrate consistent implementation of procedures for promoting accurate controlled drug records. 28 Pa Code 211.12 (c)(d)(1)(3)(5) Nursing service. 28 Pa Code 211.9 (c)(k) Pharmacy services. 28 Pa Code 211.5(f)(x) Clinical records.</p>		

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<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on clinical record review and staff interview, it was determined that the attending physician failed to document a clinical rationale for declining the pharmacist ' s identified irregularities in the medication regimen for one resident (Resident 49) out of five sampled residents reviewed for unnecessary medications. Findings include: A review of the clinical record revealed that Resident 49 was admitted to the facility on [DATE], with diagnoses that included unspecified dementia without behavioral disturbance (a condition characterized primarily by memory loss and cognitive decline without significant behavioral changes), encephalopathy (a general term describing brain disease or malfunction that can cause symptoms ranging from mild confusion to severe cognitive impairment or coma), respiratory failure (a serious condition in which the lungs cannot adequately oxygenate the blood), and a history of multiple falls. A review of a consultation report completed by the facility ' s consultant pharmacist dated July 7, 2025, revealed that Resident 49 was receiving three or more central nervous system (CNS) active medications. CNS-active medications affect the brain and spinal cord, which control most body functions. These medications include drugs such as sedatives, antidepressants, antipsychotics, narcotic pain relievers, and muscle relaxants. Use of multiple CNS-active drugs can increase the risk for falls, confusion, and fractures in older adults. The pharmacist noted that Resident 49 was receiving: Lorazepam 0.5 mg one tablet twice daily, a benzodiazepine used to relieve symptoms of anxiety. Duloxetine Hydrochloride 30 mg one capsule twice daily, an antidepressant in the class of Serotonin and norepinephrine reuptake inhibitors (SSNRI) used to treat depression and nerve pain. Quetiapine Fumarate 25 mg one tablet daily, an antipsychotic medication; and Tramadol Hydrochloride 25 mg one tablet twice daily, an opioid pain reliever. The pharmacist ' s review indicated that Resident 49 had recently sustained a fall on June 24, 2025, and recommended that the attending physician re-evaluate the medication regimen and consider a gradual dose reduction (GDR) of Duloxetine to 20 milligrams twice daily (BID). (A gradual dose reduction, or GDR, refers to the stepwise tapering of a medication dosage to determine whether symptoms, conditions, or risks can be managed with a lower dose or discontinued altogether, as required under CMS regulations for unnecessary drugs.) The attending physician responded to the pharmacist ' s recommendation on July 11, 2025, and declined to implement the recommended GDR of Duloxetine. However, the physician did not document an acceptable clinical rationale in the resident ' s medical record to justify declining the pharmacist ' s recommendation. The above was reviewed with the Nursing Home Administrator (NHA) and Director of Nursing (DON) on October 1, 2025, at 4:00 PM. 28 Pa. Code 211.9 (k) Pharmacy services. 28 Pa. Code 211.12 (c) Nursing services. 28 Pa. Code 211.2 (d)(3) Medical Director.</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>Based on observation, review of select facility policy and clinical records, and staff interviews, it was determined the facility failed to adhere to acceptable storage and labeling for multi-dose medications in one of two medication carts observed (1 East Hall). Findings include: A review of the facility policy titled Storage and Expiration Dating of Medications and Biologicals, last reviewed by the facility on May 29, 2025, indicated that if a multi-use medication vial/injectable (containers intended for multiple uses for one or more patients that require puncture of the rubber stopper or seal to withdraw doses on different occasions) has been opened and accessed, the vial is to be dated and discarded within 28 days unless the manufacturer specifies a different expiration timeframe for that opened vial. An observation of the medication cart located on the 1 East Hall unit, conducted on October 1, 2025, at 8:22 AM in the presence of Employee 3 (Licensed Practical Nurse), revealed one (1) multi-dose insulin pen of Insulin Aspart (a short-acting insulin medication used to lower blood sugar levels in individuals with diabetes mellitus) and three (3) multi-dose insulin pens of Insulin Glargine (a long-acting insulin medication used to lower and stabilize blood sugar levels over an extended period) that had been opened and were available for resident use but were not dated with the date opened or expiration date. Each pen had a manufacturer-provided label with a designated space for documenting the date opened and the corresponding expiration date, which had been left blank. Further observation revealed one (1) multi-dose insulin pen of Insulin Glargine (a long-acting insulin used to control blood sugar levels in residents with diabetes) with a sticker affixed to the pen that was blank, indicating it had been opened and was currently in use but lacked documentation of the date opened or expiration date. A review of the manufacturer's storage and safety instructions for Insulin Glargine revealed that once opened, the pen must be discarded after 28 days (the time period after which a medication is no longer considered safe or effective due to potential chemical degradation or loss of sterility). The manufacturer's guidance specifies that the date the pen is opened and the corresponding expiration date (defined as the final date a medication may be used safely and effectively before it is to be discarded) must be recorded to ensure compliance with manufacturer recommendations. An interview with Employee 3 (LPN) conducted on October 2, 2025, at 8:24 AM, confirmed that the three (3) multi-dose insulin pens of Insulin Glargine and one (1) Insulin Aspart pen were open, in current use, and not dated to reflect the date opened or the calculated expiration date. Employee 3 acknowledged that the multi-dose pen of Insulin Glargine was in use but had never been dated when opened. An interview with the Nursing Home Administrator (NHA) on October 2, 2025, at approximately 11:00 AM, confirmed that staff adhere to the facility policy regarding the dating and storage of multi-dose insulin pens in accordance with manufacturer labeling and expiration requirements. 28 Pa. Code 211.9(a)(1)(k) Pharmacy services 28 Pa. Code 211.10(c)(d) Resident care policies. 28 Pa. Code 211.12(c)(d)(1)(5) Nursing services</p>		