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	07/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dunmore Health Care Center	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)
F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of facility policy, clinical record review, medication administration records, physician orders, and staff interview, it was determined the facility failed to document that individualized non-pharmacological interventions were attempted prior to the administration of a PRN (as needed) psychotropic medication and failed to obtain and document the prescribing practitioner's clinical rationale and duration supporting continuation of the PRN psychotropic medication beyond the federally permitted 14-day period for one of 19 residents reviewed (Resident 35).Findings Include: Federal requirements for the use of psychotropic medications expect that psychotropic medications are used only when necessary to treat a specific, documented condition. A PRN (as needed) psychotropic medication order is limited to 14 days unless the prescribing practitioner documents the clinical rationale for extending the order and specifies the duration of the extension. Non-pharmacological interventions are approaches that do not involve medications, such as reassurance, redirection, environmental modifications, distraction techniques, or comfort measures. When clinically appropriate, these interventions should be attempted and documented prior to administering a PRN psychotropic medication. A review of the facility's policy titled Psychoactive Medication Policy reviewed June 25, 2026, indicated that all residents receiving psychoactive medications will have their behaviors, effectiveness of interventions (pharmacological and non-pharmacological) and potential for a gradual dose reduction of psychoactive medication monitored and documented. The policy further revealed that individualized non-pharmacological approaches are provided as part of a supportive physical and psychological environment and are directed toward preventing, relieving, or accommodating a resident's distressed behavior. Clinical record review revealed Resident 35 was admitted on [DATE], with diagnoses including depression (a common, serious mood disorder that causes persistent sadness, loss of interest, and physical fatigue) and anxiety (the body's natural response to stress, characterized by feelings of tension, worried thoughts, and physical changes). A review of Resident 35's Quarterly Minimum Data Set assessment (MDS, a federally mandated standardized assessment process conducted periodically to plan resident care) dated June 23, 2026, revealed that Resident 35 was moderately cognitively impaired with a BIMS score of 12 (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 8 through 12 indicates moderate cognitive impairment). Review of physician orders revealed an order dated May 22, 2026, for Hydroxyzine 25mg (antihistamine that has anxiolytic or anti-anxiety properties. When prescribed to treat anxiety or other behavioral or psychological symptoms, it is considered a psychotropic medication under the federal requirements governing PRN psychotropic medications) administer 1 tablet by mouth at bedtime as needed for anxiety for 14 days. Review of physician orders further revealed the order was changed on June 19, 2026, to Hydroxyzine 25 mg, administer one tablet by mouth twice daily as needed. Review of the Medication Administration Record (MAR) revealed the PRN Hydroxyzine was administered on the following occasions:May 26, 2026, at 12:45 AMJune 1, 2026, at 8:28 PMJune 5, 2026, at 8:41 PMJune 6, 2026, at 10:56 PM Review (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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	of the clinical record failed to identify documentation that non-pharmacological interventions were attempted or ineffective prior to administration of the PRN psychotropic medication on any of the seven occasions. As a result, the facility could not demonstrate that less restrictive interventions were considered before the medication was administered. Review of the clinical record failed to identify documentation that individualized non-pharmacological interventions were attempted or found to be ineffective before the PRN Hydroxyzine was administered on any of the four identified occasions. Therefore, the facility could not demonstrate less restrictive interventions were considered before administering the psychotropic medication. Review of the clinical record further failed to identify documentation from the prescribing practitioner providing the clinical rationale for continuing the PRN Hydroxyzine order beyond the 14-day federal limitation. In addition, the record failed to identify documentation specifying the duration of the extension. During an interview on July 9, 2026, at 12:30 PM, the surveyor reviewed the above findings with facility staff. The facility could not provide documented evidence that non-pharmacological interventions were attempted before the PRN Hydroxyzine was administered on the four identified occasions and no documented clinical rationale or specified duration from the prescribing practitioner supporting continuation of the PRN psychotropic medication beyond 14 days. 28 Pa. Code 211.2(3) Medical director.28 Pa. Code 211.5(ii)(xi) Clinical records.28 Pa. Code 211.8(e) Use of restraints.28 Pa. Code 211.9(1) Pharmacy services.

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on select facility policy, a review of 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 ensure licensed nurses administered medications according to physician ordered parameters for 1 of 19 residents reviewed (Resident 45). Findings include: A review of the facility policy titled, General Dose Preparation and Medication Administration, last reviewed June 25, 2026, indicated medications will be administered as ordered by the physician and vital signs (e.g., blood pressure and pulse) should be obtained if ordered by the physician. Resident 45 was admitted to the facility on [DATE], with diagnoses to include hypertension (a chronic condition in which the force of blood pushing against artery walls is consistently too high) and hyperlipidemia (abnormally high levels of fats, like cholesterol and triglycerides, in the blood). A review of the physician's orders revealed an order dated June 24, 2026, for midodrine (a prescription medication used to treat symptomatic hypotension, or low blood pressure) 10 mg, one tablet by mouth three times daily. The order directed staff to hold (not administer) the medication if the resident's systolic blood pressure (the top number of a blood pressure reading, representing the pressure in the arteries when the heart contracts) was greater than or equal to 120 mmHg (millimeters of mercury) or if the diastolic blood pressure (the bottom number of a blood pressure reading, representing the pressure in the arteries while the heart is resting between beats) was greater than or equal to 80 mmHg. A review of the medication administration records and documented blood pressure readings revealed facility staff administered midodrine on multiple occasions even though the resident's blood pressure met or exceeded the physician's ordered parameters requiring the medication to be withheld. Specifically, staff administered the medication on the following dates despite blood pressure readings at or above the physician's hold parameters: June 24, 2026, at 6:00 p.m.: blood pressure 125/72 (systolic above the ordered hold parameter).June 25, 2026, at 10:00 a.m.: blood pressure 125/74 (systolic above the ordered hold parameter).June 26, 2026, at 10:00 a.m.: blood pressure 122/80 (both the systolic and diastolic met or exceeded the ordered hold parameters).July 1, 2026, at 6:00 p.m.: blood pressure 112/80 (diastolic met the ordered hold parameter).July 5, 2026, at 2:00 p.m.: blood pressure 126/66 (systolic above the ordered hold parameter).July 5, 2026, at 6:00 p.m.: blood pressure 122/68 (systolic above the ordered hold parameter).July 6, 2026, at 10:00 a.m.: blood pressure 126/68 (systolic above the ordered hold parameter).July 6, 2026, at 2:00 p.m.: blood pressure 126/68 (systolic above the ordered hold parameter). An interview with the Nursing Home Administrator on July 9, 2026, at 1:30 PM reviewed the above findings. The Nursing Home Administrator acknowledged facility staff administered the medication despite blood pressure readings that met the physician's ordered parameters requiring the medication to be withheld. 28 Pa. Code 211.5(f)(ix) Medical Records.28 Pa. Code 211.12(c)(d)(3)(5) Nursing Services.

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility policy review, observations, and staff interviews, it was determined the facility failed to ensure residents received necessary treatment and services consistent with professional standards of practice to promote healing of existing pressure injuries for one of 19 residents reviewed (Residents 5).Findings include: According to the US Department of Health and Human Services, Agency for Healthcare Research & Quality, the pressure ulcer best practice bundle incorporates three critical components in preventing pressure ulcers: Comprehensive skin assessment, standardized pressure ulcer risk assessment, and care planning and implementation to address the areas of risk. The American College of Physicians (ACP) is a national organization of internists, who specialize in the diagnosis, treatment, and care of adults. The largest medical-specialty organization and second-largest physician group in the United States, Clinical Practice Guidelines, indicate that the treatment of pressure ulcers should involve multiple tactics aimed at alleviating the conditions contributing to ulcer development (i.e., support surfaces, repositioning, and nutritional support); protecting the wound from contamination and creating and maintaining a clean wound environment; promoting tissue healing via local wound applications, debridement, and wound cleansing; using adjunctive therapies; and considering possible surgical repair. A review of the facility policy entitled Pressure Injury Prevention and Management Policy, last reviewed by the facility on June 25, 2026, revealed it was the policy of the facility that residents admitted with existing pressure injuries will receive necessary treatments and services consistent with professional standards of practice to promote wound healing and prevent infection. A clinical record review revealed Resident 5 was admitted to the facility on [DATE], with diagnoses including chronic peripheral venous insufficiency (a condition in which the veins in the legs are unable to efficiently return blood to the heart with symptoms that include swelling in the legs or ankles, pain or throbbing in the legs, aching or tiredness in the legs, skin darkening or reddening, development of sores or ulcers) and cellulitis (a bacterial infection of the skin and underlying tissues, causing redness, swelling, warmth, and pain) right lower leg. A review of Resident 5's admission Minimum Data Set assessment (MDS, a federally mandated standardized assessment process conducted periodically to plan resident care) dated June 10, 2026, revealed that Resident 5 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 at the time of assessment, Resident 5 had one unstageable pressure ulcer (a serious wound where full-thickness skin and tissue loss has occurred, but the true depth of the damage cannot be determined because it is obscured by dead tissue) that was present on admission. A review of physician orders revealed an order dated July 3, 2026, at 4:31 PM, directing staff to apply xeroform gauze (a sterile, non-adherent wound dressing) to the distal aspect of the right buttock wound, pack the wound with Kerlix gauze soaked in Dakin's solution (an antiseptic solution used to clean wounds and reduce bacteria), and secure the dressing with an ABD pad (a thick, highly absorbent dressing) twice daily and additionally as needed for soiled or dislodged dressings. An observation conducted on July 8, 2026, at 1:15 PM, in the presence of the Assistant Director of Nursing (ADON), revealed Resident 5's right buttock wound was not covered with xeroform gauze and contained no wound packing as ordered by the physician. A second observation conducted on July 9, 2026, at 8:51 AM, in the presence of Employee 1, Licensed Practical Nurse (LPN), revealed the dressing was visibly soiled with a yellow-colored substance, and the wound packing was protruding from the wound. During the observation, Employee 1 confirmed the wound dressing was soiled and acknowledged being unable to determine when the treatment had last been changed because the dressing was not dated or timed. During an interview on July 9, 2026, at 11:30 AM, the Assistant Director of Nursing reviewed and (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	acknowledged the above findings. The facility failed to ensure Resident 5 received the physician-ordered wound treatment necessary to promote healing of an unstageable pressure injury. The physician-ordered xeroform dressing and wound packing were not in place during observation, and the wound dressing was later observed to be soiled with packing protruding from the wound without documentation identifying when the treatment had last been changed. The facility failed to provide treatment and services consistent with professional standards of practice to promote healing and prevent complications of a pressure injury. 28 Pa. Code 201.18(b)(1) Management. 28 Pa. Code 211.10(c)(d) Resident care policies. 28 Pa. Code 211.12(c)(d)(1)(3)(5) Nursing services.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, review of selected facility policies, and staff interview, it was determined the facility failed to provide pain management in accordance with physician orders and facility policy by failing to administer opioid pain medication within the physician-prescribed pain intensity scale and by failing to attempt and document non-pharmacological interventions before administering as needed (PRN) opioid pain medication for two of 19 residents reviewed (Residents 30 and 47).Findings include: A review of the facility policy titled Pain Management Protocol, last reviewed by the facility on June 25, 2026, indicated residents will be assessed for the presence and severity of pain using an appropriate pain assessment scale, such as a numeric pain rating scale, facial pain scale, or verbal descriptor scale. A numeric pain rating scale measures pain intensity from 0 through 10, with 0 indicating no pain and 10 indicating the worst pain imaginable. The policy indicated non-pharmacological interventions (treatments used to help relieve pain without medication, such as repositioning, applying ice or heat, relaxation techniques, distraction, or other comfort measures) should be attempted before administering PRN (as needed) pain medication. If non-pharmacological interventions are ineffective and multiple PRN pain medications are available based on pain severity, staff are to administer the medication corresponding to the physician-ordered pain intensity. The policy also required documentation of medication administration and the resident's response in the electronic Medication Administration Record (eMAR), an electronic record used to document medications administered to each resident. A review of Resident 30's clinical record revealed the resident was admitted to the facility on [DATE], with diagnoses including hydrocephalus (a condition caused by an abnormal buildup of cerebrospinal fluid around the brain), neuropathy (damage to the nerves that can cause numbness, tingling, burning, or pain, most commonly in the hands and feet), and chronic back pain. A review of physician orders revealed an order dated May 12, 2026, at 11:22 AM, for oxycodone hydrochloride (HCl) 5 milligrams (mg) (an opioid medication used to treat moderate to severe pain), to administer one tablet by mouth every four hours as needed for severe breakthrough lower back pain rated 7 through 10. A review of the resident's electronic Medication Administration Record (eMAR) dated June 1, 2026, through June 30, 2026, revealed licensed nursing staff administered oxycodone outside the physician-prescribed pain intensity range on the following dates: A review of the resident's electronic Medication Administration Record (eMAR) dated June 1, 2026, through June 30, 2026, revealed licensed nursing staff administered oxycodone outside the physician-prescribed pain intensity range on the following occasions: June 13, 2026, at 1:43 PM, oxycodone 5 mg was administered for a documented pain level of 4.June 14, 2026, at 11:39 AM, oxycodone 5 mg was administered for a documented pain level of 5.June 30, 2026, at 9:15 PM, oxycodone 5 mg was administered for a documented pain level of 6. These documented pain ratings were below the physician-ordered range of 7 through 10 for administration of oxycodone.The facility failed to ensure licensed nursing staff administered Resident 30's opioid pain medication according to the physician's prescribed pain intensity scale. During an interview on July 8, 2026, at 10:55 AM, the Director of Nursing (DON) reviewed the above findings and confirmed the facility failed to ensure licensed nursing staff administered oxycodone in accordance with the physician's order for Resident 30. A review of Resident 47's clinical record revealed the resident was admitted to the facility on [DATE], with diagnoses including aftercare following right total knee replacement surgery and chronic kidney disease (a condition in which the kidneys gradually lose their ability to filter waste and excess fluid from the blood). A review of a quarterly Minimum Data Set assessment (MDS-a federally mandated standardized assessment process conducted periodically to plan resident care) dated June 4 , 2026, revealed that Resident 47 is 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 13-15 indicates (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	cognition is intact). A review of physician orders revealed an order dated June 1, 2026, for oxycodone-acetaminophen 5 mg/325 mg (oxycodone is an opioid narcotic medication used to treat pain, and acetaminophen is a pain reliever and fever-reducing medication), to administer one tablet by mouth every four hours as needed for moderate to severe pain rated 4 through 10. A review of the resident's electronic Medication Administration Record (eMAR) for June 2026 revealed licensed nursing staff administered the PRN opioid medication without documenting a pain rating and without documenting attempted non-pharmacological interventions on the following dates: June 1, 2026, at 7:44 PMJune 2, 2026, at 2:21 AMJune 2, 2026, at 8:44 AMJune 2, 2026, at 12:54 PMJune 2, 2026, at 5:08 PMJune 2, 2026, at 9:09 PMJune 3, 2026, at 1:10 AMJune 3, 2026, at 5:28 AMJune 3, 2026, at 9:31 AMJune 3, 2026, at 2:26 PMJune 3, 2026, at 8:42 PM The facility failed to document the resident's pain level before administering the PRN opioid medication and failed to document that non-pharmacological interventions were attempted before administering the medication, as required by the physician's order and the facility's pain management policy. During an interview on July 8, 2026, at 11:00 AM, the Director of Nursing reviewed the above findings and confirmed the facility failed to ensure Resident 47's pain management was provided in accordance with physician orders, facility policy, and accepted standards of practice, including assessment of pain severity and documentation of attempted non-pharmacological interventions before administering PRN opioid pain medication. 28 Pa Code 211.10 (c) Resident care policies.28 Pa. Code 211.5(f) Medical records.28 Pa. Code 211.12 (c)(d)(1)(5) Nursing Services.