STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395570	A. Building B. Wing	03/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Milton Rehabilitation and Nursing Center	743 Mahoning Street Milton, PA 17847

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. Based on clinical record review, observation, and resident and staff interview, it was determined that the facility failed to accommodate resident needs regarding the accessibility of a call bell for three of six residents reviewed (Resident 1, 2, and 3). Findings include Clinical record review for Resident 1 revealed a diagnosis list that included the following: dementia (general term to describe a group of symptoms related to loss of memory, judgment, language, complex motor skills, and other intellectual function, caused by the permanent damage or death of the brain's nerve cells), difficulty in walking, generalized muscle weakness, unsteadiness on feet, need for assistance for personal care, muscle wasting and atrophy (decrease in size or wasting away), abnormal posture, and a cataract (a cloudy area in the lens of the eye that may impact vision). Review of the current care plan for Resident 1 revealed an activities of daily living (ADL) self-care performance deficit related to decreased physical ability, generalized weakness, blindness, and unsteadiness on feet. An intervention included, Encourage the resident to use bell to call for assistance. Further review of Resident 1's care plan revealed the resident has a potential for falls due to impaired vision, blindness, unsteadiness on feet with generalized weakness, and medication history. An intervention included to, Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. Observation on the [NAME] Nursing Unit on March 28, 2025, at 11:24 AM revealed a resident could be heard yelling loudly from one of the resident rooms. The resident was heard repeatedly yelling for a urine collection device and was also heard yelling, Or you're gonna have a mess again. The resident could be heard yelling by the surveyor from two rooms away and around a corner. Further observation revealed the resident yelling was Resident 1 who was in his room on March 28, 2025, at 11:29 AM. The resident was sitting in a wheelchair near the foot of the bed and facing the unmade bed. There was a bedside table between the resident and the bed, and the resident was eating a snack at the bedside table. The resident's roommate was also present. Observation revealed the resident's call bell was at the head of the bed, which was at least six feet from the resident. Upon the surveyor entering the room and attempting to question Resident 1, an unidentified staff member arrived and assisted the resident. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further observation of Resident 1 on March 28, 2025, at 12:41 PM revealed the resident was sitting in a wheelchair at the foot of the bed and facing the bed. There was a bedside table between the resident and the bed, and staff were passing out lunch food trays. The resident's bed was now made, and the call bell was at the head of the bed and now covered up by blankets. Clinical record review for Resident 2 revealed a diagnosis list that included the following: muscle wasting and atrophy, difficulty in walking, unsteadiness on feet, and unspecified lack of coordination. Review of the current care plan for Resident 2 revealed an ADL self-care performance deficit related to generalized weakness. An intervention included, Encourage the resident to use bell to call for assistance. Further review of Resident 2's care plan revealed the resident has a potential for falls due to a history of falls, impaired mobility secondary to generalized weakness, ambulatory dysfunction (difficulty with walking), and medication history. An intervention included, Place call light and frequently used objects within reach and encourage calling for assistance if needed. Observation of Resident 2 on March 28, 2025, at 11:40 AM revealed they were lying in bed. The resident's call bell was not visible by the surveyor. A concurrent interview with Resident 2 questioning the location of the resident's call bell revealed the resident attempted to search on top and under the blankets and reach towards the side of the bed. The resident was unable to locate the call bell. Further observation of Resident 2's bed revealed the call bell was clipped to the outer perimeter of the mattress, near the top of the bed, on the resident's right side of the bed. The activator was hanging away from the bed. Further observation revealed the resident was still unable to access the call bell. Clinical record review for Resident 3 revealed a diagnosis list that included the following: dementia, repeated falls, muscle weakness, cataract, and abnormal posture. Review of the care plan for Resident 3 revealed an ADL self-care performance deficit related to inability to care for self, secondary to the dementia process, generalized weakness, and unsteadiness on feet. An intervention included, Encourage the resident to use bell to call for assistance. Further review of Resident 3's care plan revealed the resident has a potential for falls and has had actual falls due to unsteady gait and ambulating independently secondary to impaired cognition with poor safety awareness due to the dementia process. An intervention included, Place call light and frequently used objects within reach and encourage calling for assistance if needed. Observation of Resident 3 on March 28, 2025, at 11:54 AM revealed the resident was sitting in a wheelchair at the foot of the bed. An attempted interview with the resident revealed the resident did not respond to the surveyor. Observation of Resident 3's room revealed the call bell was not visible. Further observation revealed the call bell was found underneath a large stuffed animal at the head of the bed, inaccessible to Resident 3. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The findings for Residents 1, 2, and 3 were reviewed in a meeting with the Nursing Home Administrator (NHA) on March 28, 2025, at 12:30 PM. The NHA further noted that Resident 3 is independent and probably placed the stuffed animal on the call bell because the resident is particular with the way things are placed in the room. However, there was no intervention in the care plan that instructed staff on the preferred placement of Resident 3's call bell. The facility failed to accommodate resident needs regarding the accessibility of call bells. 28 Pa. Code 211.12(d)(1)(5) Nursing services