

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  395625	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  07/25/2024
NAME OF PROVIDER OR SUPPLIER  Marywood Heights		STREET ADDRESS, CITY, STATE, ZIP CODE 2500 Adams Avenue Scranton, PA 18509	

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 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41460</b></p> <p>Based on a review of clinical records and the Resident Assessment Instrument and staff interview, it was determined that the facility failed to ensure that the Minimum Data Set Assessments (MDS - a federally mandated standardized assessment conducted at specific intervals to plan resident care) accurately reflected the status of one resident out of 19 sampled (Resident 13).</p> <p>Findings included:</p> <p>Clinical record review revealed that Resident 13 was admitted to the facility on [DATE], with diagnoses which included hemiplegia and hemiparesis following a stroke affecting left non-dominant side, bipolar disorder, and anxiety.</p> <p>Review of Resident 13's transfer paperwork revealed that the resident was at high risk for falls and had last experienced a fall on May 24, 2024.</p> <p>A review of Resident 13's Admission MDS assessment dated [DATE], Section J - Health Conditions, question J1700 Fall History on Admission/Entry or Reentry, did the resident have a fall any time in the last month prior to admission/entry or reentry, revealed that the coded answer was 0 which indicated no.</p> <p>There was no evidence that Resident 13's Admission assessment accurately identified the resident's fall history.</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>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** 48277</b></p> <p>Based on review of clinical records and staff interview it was determined that the facility failed to provide care and services according to accepted standards of clinical practice in the identification of a resident's diagnosis of bipolar disorder for one resident (Resident 41) out of 19 residents sampled.</p> <p>Findings include:</p> <p>A review of the Resident 41's clinical record revealed that the resident was admitted to the facility on [DATE], with three psychiatric/mood disorders: major depressive disorder, anxiety disorder, and obsessive-compulsive disorder.</p> <p>A review of Resident 41's resident's medical diagnosis list revealed a diagnosis of bipolar disorder, was added on April 4, 2023.</p> <p>A review of a physician progress note dated April 30, 2023, at 4:32 PM revealed that the physician examined the resident who presented with severe anxiety. Since the previous dose reduction and reintroduction (of medications), the resident has not responded to medical management. The physician indicated that her impression was the resident had bipolar depression. The plan of treatment was to change Seroquel (antipsychotic medication) to Zyprexa (antipsychotic medication) and discharge Atarax (medication used to treat anxiety).</p> <p>Review of Resident 41's Documentation Survey Report v2, Monitor-Behavior Symptoms dated April 2023, revealed staff documented on the resident's behavior daily. The report indicated that there were no days in April where Resident 41 exhibited adverse behaviors such as frequent crying, repeated movements, yelling/screaming, kicking/hitting, pushing, grabbing, pinching/scratching/spitting, biting, wandering, abusive language, threatening behavior, sexually inappropriate, and rejection of care. All entries made by staff indicated that none of the above observed.</p> <p>A review of Resident 41's comprehensive plan of care initially dated July 12, 2023, and revised April 17, 2024, revealed a significant change in mental condition with a diagnosis of bipolar disorder. The interventions included monitoring behavior and mood and administer medications as prescribed.</p> <p>Review of a psychiatry consult dated October 11, 2023, revealed that the resident was diagnosed with generalized anxiety disorder.</p> <p>There was no documented evidence in the resident's clinical record to demonstrate that a clinical practitioner had diagnosed the resident with bipolar disorder with documented supporting clinical findings in the resident's clinical record from the time of the resident's admission to the facility on [DATE], through the current survey which ended on July 25, 2024.</p> <p>Interview with the Director of Nursing on July 24, 2024, at 1:40 PM, confirmed that the facility did not have documented evidence of a practitioner diagnosing the resident with bipolar disorder according to professional standards.</p> <p>(continued on next page)</p>		

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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>28 Pa. Code 211.2 (d)(3) Medical Director</p> <p>28 Pa. Code 211.5 (f) Medical records</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>48277</p> <p>Based on observation, review of clinical records, and resident and staff interviews it was determined that the facility failed to provide services consistent with professional standards of practice by failing to follow physician orders for bowel protocol for one resident (Resident 24) to promote normal bowel activity to the extent practicable and failed to follow physician orders for the consistent application of a prescribed therapeutic measure, Darco shoes, for one resident of 19 sampled (Resident 55).</p> <p>Findings include:</p> <p>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).</p> <p>A review of the clinical record revealed that Resident 24 had physician orders, dated February 27, 2024, for the following bowel regimen:</p> <ul style="list-style-type: none"> <li>- Milk of Magnesia (MOM) Suspension 7.75% (Magnesium Hydroxide), give 30 ml by mouth as needed for constipation. Give 30 ml on evening shift if no BM (bowel movement) by day 3.</li> <li>-Biscolax Suppository 10 mg (Bisacodyl), inset 1 suppository rectally as needed for constipation. Give on evening shift if no BM by day 4 if MOM is not effective.</li> <li>-Fleet Bisacodyl Enema 10 mg/30 ml (Bisacodyl), insert 1 applicatorful rectally as needed for constipation. Give on evening shift on day 5 if suppository is not effective. If not effective notify MD (physician).</li> </ul> <p>Review of Resident 24's Documentation Survey Report v2 for July 2024, revealed that Resident 24 did not have a bowel movement on July 4, 5, 6, 7, 8, 9, 2024.</p> <p>Review of Resident's Medication Administration Record (MAR) for July 2024, revealed no documented evidence that nursing administered the prescribed bowel protocol during the time period without a bowel movement to promote bowel activity.</p> <p>There was no documented evidence that the staff had notified the physician that the resident went six consecutive days, July 4, 5, 6, 7, 8, 9, 2024, without a bowel movement.</p> <p>During an interview with the Director of Nursing (DON) on July 24, 2024, at 1:10 PM, the DON was unable to provide evidence that physician ordered bowel protocol was followed for Resident 24 during the period without bowel activity stated above, nor evidence of timely physician notification.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of Resident 55's clinical record revealed a physician's order dated March 20, 2024, for the application of a heel off DARCO shoe (specialty shoe designed to off-load pressure from the heel by shifting weight to the mid and forefront of the foot to promote faster healing of a wound), to the RLE (right lower extremity), and a DARCO shoe to the LLE (left lower extremity).</p> <p>Observation of Resident 55 sitting in his wheelchair in the common area on July 23, 2024, at 12:45 PM, July 24, 2024, at 11:10 AM, and July 25, 2024, at 11:20 AM, revealed that the resident was not wearing a heel off DARCO shoe to his RLE or a DARCO shoe to his LLE as ordered at the time of each observation. Instead, the resident was wearing a pair of socks with sandals.</p> <p>During an interview with Resident 55 on July 23, 2024, at 12:45 PM, he reported that he does not wear DARCO shoes and only wears the socks and sandals that he was currently wearing.</p> <p>Interview with Employee 2 (licensed practical nurse) on July 25, 2024, at 11:20 AM, verified that Resident 55 had a physician's order for a heel off DARCO shoe to the RLE and a DARCO shoe to the LLE. Employee 2 confirmed that the resident was not wearing the DARCO shoes on his bilateral lower extremities at the time observed.</p> <p>During an interview on July 25, 2024, at approximately 12:30 PM, the Nursing Home Administrator and Director of Nursing confirmed that the staff had not followed the physician order for the application of the physician prescribed DARCO shoes.</p> <p>28 Pa. Code 211.12 (d)(3)(5) Nursing services</p> <p>28 Pa. Code 211.5(f) Medical records</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 39929</p> <p>Based on a review of clinical records and select investigation reports and staff interviews, it was determined that the facility failed to provide necessary supervision, and implement effective individualized safety measures for a resident with known unsafe behaviors to prevent multiple falls for one resident (Resident 13) and a serious burn, to one resident (Resident 27) out of 19 residents sampled.</p> <p>Findings include:</p> <p>A review of Resident 27's clinical record revealed that the resident was admitted to the facility April 14, 2023, with diagnoses to include hemiplegia and hemiparesis following nontraumatic intracerebral hemorrhage affecting left dominant side. (Hemiparesis, also called unilateral paresis, is the weakness of one entire side of the body. Hemiplegia, in its most severe form, is the complete paralysis of one entire side of the body).</p> <p>A quarterly Minimum Data Set assessment (MDS - a federally mandated standardized assessment process conducted at specific intervals to plan resident care) dated May 15, 2024, revealed that the resident was severely cognitively impaired with a BIMS score of 6 (Brief Interview for Mental Status, a tool to assess the resident's attention, orientation, and ability to register and recall new information). The resident required supervision and the assistance of one staff person when eating according to the MDS assessment.</p> <p>The resident had a current physician order, initially dated January 23, 2024, for the use of a Kennedy cup (a lightweight spill proof drinking cup that is used with a straw) at all meals and for the use of Divided scoop dish and built up utensils to max his ability to engage in self-feeding tasks dated November 27, 2023.</p> <p>An Occupational Therapy treatment encounter note dated December 14, 2023, the last encounter the resident had with Occupational Therapy, prior to an incident that occurred while the resident was eating on July 14, 2024, indicated that the resident required precautions due to the resident's left sided hemiplegia (paralysis on one side of the body). The resident was able to drink from a Kennedy cup and utilize built-up utensils and scoop dish with moderate staff assistance to manage eating with these assistive devices.</p> <p>Review of documentation in Resident 27's clinical record revealed the resident had multiple falls since the resident's admission to the facility on [DATE], through the time of the survey ending July 25, 2025, with progress note documentation revealing that the resident displayed frequent behaviors of restlessness and impulsivity.</p> <p>(continued on next page)</p>

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>A nurses note dated July 14, 2024, indicated that at approximately 4:00 PM Resident 27 accidentally spilled soup on his LLQ (left lower quadrant) and left groin during evening meal. Area from lower abdomen to groin erythematous with bright coloration and shiny appearance. One (1 cm) blister noted on center of LLQ area. Resident c/o pain and was medicated per order. At time of event, resident was sitting in chair at dining table, soup was placed in center of table out of exact reach, staff were present in dining room serving other residents, clothing protector was in place for protection. Resident over estimated ability to handle soup bowl independently. Resident diagnosed with left hemiplegia/hemiparesis post cerebral infarct as well as lack of coordination. Following event, nurse immediately removed source of heat and rushed [Resident 27] to wash area where clothing was removed, area soaked in cool running tap water. SSD applied. Call out to on-call provider.</p> <p>A review of the incident report completed by the facility Director of Nursing, dated July 15, 2024, revealed that Resident 27 sustained a burn while reaching for his soup, which staff placed on the table in a reachable distance from the resident, when staff turned to get an ice cube to cool the resident's soup per his preference. The incident report revealed that the dietary staff had taken the temperature of the soup in the kitchen, prior to point of service to the resident, and noted the temperature 179 degrees fahrenheit at that time. The facility staff did not obtain the temperature of the soup after it was brought to the dining room steam table, the point of service to residents, as per facility policy.</p> <p>Review of a witness statement from Employee 3, LPN, dated July 14, 2024, revealed that at dinner time, she delivered Resident 27's soup from the steam table in the dining room and set him up at the dining table to eat, thinking the soup was out of the resident's reach. Employee 3 stated she turned around to get the resident an ice cube per his preference and the resident was able to reach his soup and it spilled in his lap.</p> <p>Resident 27's clinical record revealed resident sustained a 12 cm x 15-centimeter reddened area on his left lower stomach with a 1-centimeter blister noted. A physician order dated July 15, 2024, was noted to cleanse the blister on the resident's left lower abdomen with NSS, apply Silvadene cream, non-stick dressing and optifoam daily and prn soilage/displacement.</p> <p>An Occupational Therapy consult dated July 16, 2024, after the resident sustained the burn on July 14, 2024, revealed that the resident had a decline in ability to feed himself even with the use of built up utensils, and now required moderate staff assistance during eating. The consult noted that the resident's poor safety awareness contributed to his spillage of soup and subsequent burn.</p> <p>The facility failed to consistently provide the resident with the necessary staff supervision at meals, based on the resident's known restlessness and impulsivity, to prevent a serious injury to the resident.</p> <p>Interview with the NHA and DON on July 25, 2024, at approximately 12:00 PM revealed that the facility was unable to provide evidence that staff supervised Resident 27 while eating to prevent the resident from spilling hot soup on himself sustaining painful burns.</p> <p>Clinical record review revealed that Resident 13 was admitted to the facility on [DATE], with diagnoses which included hemiplegia and hemiparesis following a stroke affecting left non-dominant side, bipolar disorder, and anxiety.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident 13's transfer paperwork the facility received from a prior skilled nursing facility revealed that the resident was at high risk for falls. The sending [NAME] nursing facility provided this current facility with the resident's plan of care, which included all interventions implemented for safety. These interventions included to encourage the resident to be out of bed for all meals, placement of a fall mat to left side of bed while resident in bed, low bed- keep in lowest position (bed controls out of resident's reach), offer to adjust temperature when placed in bed, offer toileting between 1:30 PM and 2:30 PM and change (incontinence care) if needed, pad alarm to bed hung behind headboard [control box] to alert staff of self-transfers and check functioning and placement every shift, resident request is to be in bed between 7:30 PM and 8 PM, resident to be out of bed in wheelchair with rearward tilt of wheelchair seat, thicker fall mat to window side (left) side of bed when resident in bed and check every shift, keep frequently used items in reach, and high risk for falls. Resident 13's transfer documentation also revealed that she had a self-releasing seat belt with alarm to alert staff of attempts to self transfer initiated October 19, 2023, and had experienced a recent fall on May 24, 2024.</p> <p>An Admission MDS (Minimum Data Set - a federally mandated standardized assessment conducted at specific intervals to plan resident care) dated June 12, 2024, revealed that the resident was cognitively intact with a BIMS score of 15 (a score of 13 to 15 indicates no cognitive impairment).</p> <p>A Fall Morse Scale evaluation dated June 5, 2024, revealed that the resident was identified as a Moderate Fall Risk. Interventions implemented upon admission included to have call bell in reach, pain evaluation, non-skid socks, and a therapy screen.</p> <p>A review of Resident 13's baseline care plan dated June 5, 2024, revealed that interventions implemented upon admission on June 5, 2024, were to anticipate and meet resident's needs, encourage resident to use call bell for assistance as needed, and for room to be free from spills and/or clutter with adequate light.</p> <p>An incident report investigation dated June 18, 2024, revealed that at 1:45 PM, Resident 13 fell to the floor in her room while attempting to self-transfer to wheelchair from standard chair. The resident was found on the floor, lying on her left side, after the resident's roommate rang the call bell for staff assistance. According to investigation, Resident 13's roommate witnessed the fall, and Resident 13 did not sustain any injuries. Safety interventions implemented after fall included to apply dycem (non-skid material) beneath cushion.</p> <p>Review of care plan revealed that interventions added June 20, 2024, included a sensor pad to both the resident's bed and chair.</p> <p>An incident report investigation dated June 25, 2024, revealed that at 11:35 AM, staff again found the resident on the left side of her bed on the floor. She sustained a bump on the back of her head. According to the investigation, the resident stated that she was attempting to get out of bed to go out the door. The physical therapy assistant found the resident on the floor when she had returned Resident 13's roommate to their room. There was no evidence according to incident report and witness statement, that bed or chair alarms were sounding/functioning to alert staff that Resident 13 had self-transferred and on the floor. The incident report indicated that a low-bed and a medication review were to be implemented, and orders received for ice to be applied to bump on the back of resident's head, and neuro checks were initiated.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of documentation dated June 25, 2024, at 2:27 PM revealed that the resident complained of dizziness and nausea. Neuro check within normal limits with the exception of the new nausea and dizziness. Orders were received from the physician to send the resident to the emergency room for an evaluation.</p> <p>Review of emergency room evaluation dated June 25, 2024, the resident was seen after falling backwards in her bathroom, hitting the back of her head on the tile. En route to the ED [emergency department], patient offered complaints of HA [headache] accompanied by blurry vision, nausea, and dizziness. No injuries were identified and based on urinalysis, the resident returned to the facility on antibiotic for possible urinary tract infection.</p> <p>An incident report investigation dated June 29, 2024, revealed that at 6:45 AM, staff again found the resident on the floor to the left side of the resident's bed. The bed alarm was sounding and the resident's call bell within reach. According to the investigation, the resident rolled out of bed. Resident 13 then complained of left knee and left hip pain and x-rays were ordered by the physician. No fractures/injuries were identified and floor mats were to added to both sides of the resident's bed when the resident in bed (an intervention that had been in place when the resident resided at the prior skilled nursing facility and noted on the transfer form, with a thicker fall matt on the left side).</p> <p>Review of an incident report investigation dated July 7, 2024, revealed that at 10:45 AM, Resident 13's roommate rang the call bell to alert staff that Resident 13 was ambulating unassisted. Staff found Resident 13 sitting on the floor, on the left side, in front of wheelchair. According to the investigation, Resident 13 stated that she went to get my sneakers, I didn't ring because I'm stupid.</p> <p>The investigation's conclusion indicated that the resident self-removed chair alarm and attempted to ambulate across the room to retrieve item, and overestimates functional abilities and has poor safety recall. The alarm was replaced, and a therapy screen was submitted for further recommendations.</p> <p>An incident report investigation dated July 11, 2024, revealed that at 6 AM, the resident had an unwitnessed fall while attempting to self-transfer out of bed. The resident was found on window side of the bed with alarm sounding, fall mats were noted to be in place, call bell within reach, and non-skid socks in place. The resident stated she wanted to get up. According to the report, the resident had been tended to approximately 30 minutes prior to fall. Additional intervention included application of a perimeter/raised edge mattress to the resident's bed to enhance safety awareness of bed perimeter.</p> <p>A incident report investigation dated July 16, 2024, revealed that at 10:45 AM, staff found Resident 13 on the floor in the bathroom of the resident's room, sitting next to the toilet. According to the investigation, the resident stated that she transferred herself from the toilet to the wheelchair and slid to the floor.</p> <p>The investigation's conclusion, revealed that resident did not ask for assistance, requires assist of 2 staff members with rollator walker for transfers, is non-ambulatory, forgets to ask for assistance, and self-removed alarm. The resident did not sustain any injuries.</p> <p>(continued on next page)</p>		

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F 0689  Level of Harm - Actual harm  Residents Affected - Few	<p>The resident's risk for falls and need for multiple safety and fall prevention measures was included in the resident's transfer documentation upon the resident's admission to the facility. The facility failed to timely address the resident's high risk for falls and promptly implement sufficient safety and fall prevention interventions, individualized to the resident's habits and behaviors identified in the resident's transfer documentation, to prevent repeated falls, which increased the resident's risk for serious injury.</p> <p>Interview with the NHA and DON on July 25, 2024, at 11:30 AM confirmed that the facility was unable to demonstrate the implementation of necessary individualized fall prevention measures, and sufficient staff supervision at the level and frequency required, to prevent Resident 13's repeated falls.</p> <p>28 Pa Code 211.12 (d)(3)(5) Nursing services</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41460</b></p> <p>Based on a review of clinical records and staff interview, it was determined that the facility failed provided necessary care to prevent urinary tract infections to the extent possible for one resident with an indwelling urinary catheter out of 19 sampled residents (Resident 1).</p> <p>Findings included:</p> <p>Clinical record review revealed Resident 1 was admitted on [DATE], with diagnoses, which included retention of urine, acute cystitis without hematuria, urinary tract infection, and required the use of an indwelling catheter for urination.</p> <p>Review of physician orders revealed an order dated March 15, 2024, to change catheter monthly/every 30 days and as needed for blockage, leakage, or dislodgement with 16 French and a 10 cc balloon (size of catheter) on the night shift.</p> <p>Review of Treatment Administration Record dated April 2024, failed to provide evidence that the resident's catheter was changed as ordered by the physician during the month of April 2024.</p> <p>Review of clinical record revealed that on May 17, 2024, the resident had an appointment with Urology. Orders received from urology included to irrigate foley daily to prevent sediment buildup, irrigate as needed for decreased urinary output, maintain foley with changes every 4 weeks, treat only symptomatic UTI (urinary tract infection) i.e.: fevers, chills, altered mental status. According to the Urology consult, the resident's urine will always come back with growth i.e.: colonization. Maintain adequate output from foley, avoid obstruction of foley.</p> <p>Physician orders revealed an order dated May 17, 2024, to change the foley catheter monthly on the 17th during the evening shift, to irrigate the foley daily to prevent sediment build-up, and irrigate foley as needed every 8 hours for decreased urinary output. Review of the physician orders revealed that the order dated March 15, 2024, to change the catheter every 30 days continued to be active.</p> <p>There was no evidence that the nursing staff verified what was to be used to flush the foley catheter, or how much solution was to be used for flushing the catheter.</p> <p>Additional review of the TAR dated May 2024 revealed that urinary output from the foley was to be documented each shift. There was no evidence that the solution used to flush the catheter was taken into consideration when calculating total urinary output for each shift, therefore potentially providing inaccurate amount of the resident's true output of urine.</p> <p>Review of TAR dated May 2024, revealed that the resident's catheter was changed on May 17, 2024, as ordered.</p> <p>Documentation dated June 29, 2024, indicated that the resident was prescribed antibiotic therapy due to a urinary tract infection.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  Marywood Heights		STREET ADDRESS, CITY, STATE, ZIP CODE  2500 Adams Avenue Scranton, PA 18509	
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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of documentation dated July 2, 2024, at 1023 PM indicated that Resident 1 pulled out the foley catheter and a new one was inserted.</p> <p>Review of the TAR dated July 2024, failed to provide documented evidence that the resident's catheter was changed on July 2, 2024. Further review of the TAR revealed that the resident's catheter was documented as being changed on July 16, 2024, and again July 17, 2024, due to the duplicate orders remaining in the resident's record.</p> <p>There was no evidence that the nursing staff referred to the orders from Urology to change the catheter every 4 weeks.</p> <p>Observation on July 23, 2024, at 11:30 AM, revealed an undated bulb piston syringe, and an undated, unlabeled, opened 1000 mL bottle of sterile water with approximately 600 mL remaining in the bottle setting on top of a 3-drawer cart in Resident 1's bathroom.</p> <p>Interview with Employee 1, licensed practical nurse (LPN), confirmed the observation. Employee 1 further confirmed that there was no evidence of how old the items were, and that the items were not stored in a sanitary manner.</p> <p>At time of survey ending July 25, 2024, there was no evidence that the nursing staff had verified the orders received from Urology on May 15, 2024, regarding flushing of the resident's catheter.</p> <p>Interview with the Director of Nursing on July 25, 2024, at approximately 2 PM, confirmed that the facility failed to provide appropriate care and services for a resident with and indwelling catheter and recurring urinary tract infections.</p> <p>Refer F880</p> <p>28 Pa. Code 211.12 (d)(3)(5) Nursing services</p> <p>28 Pa. Code 211.10 (a)(c)(d) Resident care policies</p>		

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<p>F 0740</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident must receive and the facility must provide necessary behavioral health care and services.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 39929</p> <p>Based on review of clinical records and staff interview it was determined that the facility failed to consistently provide necessary services to meet the behavioral health needs of one of 19 sampled residents (Resident 27).</p> <p>Findings include:</p> <p>Review of the clinical record revealed that Resident 27 was admitted to the facility on [DATE], and had diagnoses, which included major depressive disorder.</p> <p>Resident 27's clinical record revealed documentation dated from the time of the resident's admission through the survey ending July 25, 2024, that the resident had consistent behavioral symptoms of yelling out repeatedly. These episodes occurred almost daily and not easily redirectable.</p> <p>Review of Resident 27's care plan in effect at time of survey ending July 25, 2024, revealed a focus area related to the resident's history of depression with an intervention for psyche follow ups as ordered/scheduled.</p> <p>A review of Resident 27's clinical record revealed the resident had an appointment with a psychiatrist scheduled for May 28, 2024. This appointment was canceled due to the facility being unable to provide transportation for the resident to attend the appointment. Further review revealed that this appointment was not yet rescheduled as of end of survey July 25, 2024.</p> <p>There was no documented evidence that Resident 27 was provided timely follow-up psych services treatment thru the time of the survey ending July 25, 2024.</p> <p>During an interview with the Nursing Home Administrator (NHA), on July 24, 2024, at approximately 11:00 a. m., the NHA was unable to provide evidence that Resident 27 had received psychological/psychiatric services as recommended.</p> <p>28 Pa. Code 211.2 (d)(8) Medical director</p>		

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<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</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> 39929</p> <p>Based on review clinical records and medication administration record, and staff interview, it was determined that the facility failed to ensure that the attending physician acted upon on the pharmacist's reports of irregularities in the drug regimen of one resident of 19 residents reviewed (Resident 41).</p> <p>Findings include:</p> <p>Review of Resident 41's clinical record revealed admission to the facility on [DATE], with diagnoses that included major depressive disorder (major loss of interest in pleasurable activities), anxiety disorder, obsessive-compulsive disorder and dementia (a chronic or persistent disorder of the mental processes caused by brain disease or injury and marked by memory disorders, personality changes, and impaired reasoning).</p> <p>Review of the consultant pharmacist's Note to Attending Physician/Prescriber dated January 24, 2024, addressed the physician's order for Ativan (an antianxiety medication) 0.5 mg three times a day for anxiety. The pharmacist recommended a Gradual Dose Reduction (GDR), noting that per CMS guidelines for psychotropic drugs, a GDR must be attempted annually, unless clinically contraindicated. The pharmacist further noted that if the drug therapy is to continue, the physician must document why the risk of the adverse consequences presented by an attempted GDR exceed the benefit of the GDR due to potential negative impact on the resident's psychiatric instability, functional capacity and quality of life.</p> <p>The facility failed to provide written documentation of the attending physician's response to the consultant pharmacist's recommendation and there was no documentation that the resident's physician acknowledged this identified pharmacy report.</p> <p>Review of the consultant pharmacist's Note to Attending Physician/Prescriber dated April 24, 2024, noted that Resident 41 was prescribed three medications for anxiety: Remeron, Ativan, and Buspar with recommendation to evaluate if any of the medications could be reduced or discharged to avoid duplication of effect.</p> <p>The facility failed to provide written documentation of the attending physician's response to the consultant pharmacist's recommendation and there was no documentation that the resident's physician acknowledged this identified pharmacy report.</p> <p>Review of the consultant pharmacist's Note to Attending Physician/Prescriber dated June 26, 2024, indicated that this is the 2nd request regarding three medications for anxiety: Remeron, Ativan, and Buspar with recommendation to evaluate if any of the medications could be reduced or discharged to avoid duplication of effect.</p> <p>The facility failed to provide written documentation of the attending physician's response to the consultant pharmacist's 2nd request for recommendation and there was no documentation that the resident's physician acknowledged this identified pharmacy report.</p> <p>(continued on next page)</p>		

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<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>An interview with Director of Nursing on July 24, 2024, at approximately 2:00 PM confirmed that the facility was unable to provide documented evidence that the attending physician acted upon the pharmacy recommendations.</p> <p>28 Pa. Code 211.9 (k) Pharmacy services.</p> <p>28 Pa Code 211.5 (f) Medical records</p> <p>28 Pa. Code 211.2 (d)(7) Medical director</p>		

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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident's drug regimen must be free from unnecessary drugs.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41460</b></p> <p>Based on a review of clinical records and staff interviews it was determined that the facility failed to ensure that the resident's drug regimen was free of unnecessary antibiotic drugs for one out of 19 residents sampled (Resident 13).</p> <p>Findings included:</p> <p>Clinical record review revealed that Resident 13 was admitted to the facility on [DATE], with diagnoses which included hemiplegia and hemiparesis following a stroke affecting left non-dominant side, bipolar disorder, and anxiety and was cognitively intact.</p> <p>A review of documentation dated June 25, 2024, at 2:27 PM, revealed that the resident was sent to the emergency room for an evaluation due to complaints of dizziness and nausea after sustaining a fall in the bathroom and hitting her head earlier that day.</p> <p>Documentation dated June 25, 2024, at 11:35 PM, indicated that the resident returned to the facility with no acute injuries and an order for Keflex 500mg twice a day for 10 days for diagnosis of possible urinary tract infection and will follow-up with hospital to obtain culture results when available.</p> <p>Review of Medication Administration Record (MAR) dated June 2024, revealed that the antibiotic therapy for treatment of a possible UTI was initiated on June 26, 2024, at 8 AM.</p> <p>Documentation dated June 28, 2024, at 2:16 PM, indicated that a call was placed to the hospital to request urinalysis results that were performed on June 25, 2024. The hospital did not complete a culture and sensitivity test on the urine during the evaluation. Urinalysis results were made available and given to nursing supervisor.</p> <p>Nursing documentation dated from June 25, 2024, through July 5, 2024, revealed no documentation that the resident was displaying signs or symptoms of a UTI.</p> <p>Review of Resident 13's clinical record revealed that antibiotic therapy continued to be administered two times per day from June 26, 2024, through July 5, 2024, despite the resident not having signs/symptoms of a UTI or the necessary diagnostic studies to clinically justify the administration of the antibiotic Keflex.</p> <p>Interview with the Infection Preventionist on July 25, 2024, at approximately 12:45 PM, confirmed that the administration of Keflex was not clinically justified for treatment of Resident 13's possible UTI.</p> <p>28 Pa. Code 211.2 (3) Medical Director</p> <p>28 Pa. Code 211.9 (k) Pharmacy Services</p> <p>28 Pa. Code 211.12 (d)(1)(3) Nursing Services</p>		

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 39929</p> <p>Based on review clinical records and staff interviews, it was determined that the facility failed to ensure that a resident was free from unnecessary psychoactive drugs by failing to assure the presence of the documented prescriber clinical rationale for the use of a psychotropic medication one of five residents reviewed (Resident 45).</p> <p>Findings include:</p> <p>Review of Resident 45's clinical record revealed that the resident was admitted to the facility on [DATE], with diagnoses including dementia.</p> <p>The resident had a physician order initially dated December 10, 2023 for Xanax Oral Tablet 0.25 MG (Alprazolam) anti anxiety for anxiety.</p> <p>A review of a pharmacist consult to the physician dated June 26, 2024 reveled a request for a gradual dose reduction (GDR) for the Xanax.</p> <p>There was no physician response to this request. Further review of Resident 45's clinical record revealed that the pharmacy consult was sent to the wrong physician and at time of survey ending July 25, 2024 had not been reviewed by Resident 45's physician.</p> <p>The facility was unable to provide documented evidence to support the continued use of the current dose of Xanax or evidence that a gradual dose reduction attempt of the psychoactive medications conducted in the past year.</p> <p>During an interview with the Nursing Home Administrator (NHA) and Director of Nursing (DON) on July 24, 2024, at approximately 12:45 PM, confirmed the lack of GDR attempts for the psychoactive drugs prescribed for Resident 45.</p> <p>28 Pa. Code 211.9 (a)(1)(k) Pharmacy Services</p> <p>28 Pa. Code 211.2 (d)(3)(9) Medical Director</p> <p>28 Pa. Code 211.5 (f) Clinical records</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>41460</p> <p>Based on observation and staff interview, it was determined that the facility failed to ensure adherence to medication and pharmaceuticals expiration dates in one of 4 medication carts.</p> <p>Findings include:</p> <p>An observation of the second-floor Cart A medication cart on July 25, 2024, at 8:05 AM revealed two multidose insulin vials opened.</p> <p>One multidose vial of Lantus 100units/ mL and one multidose vial of Admelog 100units/ mL were labeled with an expiration date of July 17, 2024.</p> <p>Employee 4, licensed practical nurse, confirmed the observations of the expired medications at the time of observation.</p> <p>Interview with the Director of Nursing on July 25, 2024, at 1:33 PM confirmed that the expired medications should have been removed from the medication cart and discarded.</p> <p>28 Pa. Code 211.9 (a)(1)(k) Pharmacy Services</p> <p>28 Pa. Code 211.12 (c)(d)(3)(5) Nursing services</p>

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<p>F 0791</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide or obtain dental services for each resident.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48277</b></p> <p>Based on review of clinical records and staff interview, it was determined that the facility failed to offer routine annual dental services for one Medicaid payor source out of four residents sampled (Resident 23) for dental services.</p> <p>Findings include:</p> <p>Review of the clinical record of Resident 23 revealed admission to the facility on [DATE], and the resident's payor source was Medicaid. There was no documented evidence at the time of the survey ending July 25, 2024, that the resident had been offered dental services in the past year.</p> <p>Review of Resident 23's care plan initially dated April 13, 2020, and revised December 9, 2023, indicated that the resident declined dental visits. However, the facility was unable to provide documented evidence that the resident was offered and declined dental services for the past year.</p> <p>Interview with the Director of Nursing on July 25, 2024, at 1:27 PM confirmed that the facility had not offered Resident 23 routine dental services in the past year.</p> <p>28 Pa. Code 211.12 (c)(d)(3)(5) Nursing services</p>

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 41460</p> <p>Based on review of clinical records and resident and staff interview, it was determined that the facility failed to maintain accurate and complete clinical records, according to professional standards of practice, reflecting the medial care for three residents out of 19 sampled (Residents 13, 37 and 60).</p> <p>Findings included:</p> <p>The Pennsylvania Code, Title 49, Professional and Vocational Standards, State Board of Nursing, 21.145 Functions of the Licensed Practical Nurse (LPN) (a) The LPN is prepared to function as a member of the health-care team by exercising sound judgement based on preparation, knowledge, skills, understandings, and past experiences in nursing situations. The LPN participates in the planning, implementation, and evaluation of nursing care in settings where nursing takes place. 21.148 Standards of nursing conduct (a) A licensed practical nurse shall: (5) Document and maintain accurate records.</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>Clinical record review revealed that Resident 13 was admitted to the facility on [DATE], with diagnoses which included hemiplegia and hemiparesis following a stroke affecting left non-dominant side, bipolar disorder, and anxiety.</p> <p>Review of documentation dated June 25, 2024, at 2:27 PM revealed that Resident 13 was sent to the emergency room for an evaluation due to complaints of dizziness and nausea after sustaining a fall.</p> <p>Documentation dated June 25, 2024, at 9:53 PM indicated that Resident 13 returned to the facility at 8 PM. Verbal report was received from the hospital with instruction for the facility to administer Keflex 500mg twice a day for 10 days for a possible urinary tract infection.</p> <p>A review of the resident's clinical record conducted during the survey ending July 25, 2024, revealed no documented evidence from Resident 13's evaluation in the emergency roiaognom on [DATE], which resulted in treatment for a possible UTI.</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview with the Infection Preventionist on July 25, 2024, at 11:00 AM confirmed there was no evidence of any documentation from the emergency room evaluation of Resident 13. The Infection Preventionist produced the information at approximately 1 PM on July 25, 2024.</p> <p>Review of Resident 37's clinical record revealed admission to the facility on [DATE], with diagnoses which included Alzheimer's disease, venous insufficiency, and hypertension.</p> <p>Review of resident's immunization record failed to provide evidence that Resident 37 was screened for Tuberculosis prior to admission to the facility or annually per facility policy.</p> <p>Interview with the facility's Infection Preventionist (IP) on July 24, 2024, at approximately 10:30 AM, confirmed that the resident's clinical record did not include evidence of screening for Tuberculosis since admission to the facility.</p> <p>Review of resident screenings for Tuberculosis provided by the IP on July 24, 2024, revealed that Resident 37 had been screened according to policy, and last screening was performed in October 2023, yet the screenings were not provided in the resident's clinical record.</p> <p>Interview with the DON and Nursing Home Administrator (NHA) on July 25, 2024, at approximately 1:45 PM confirmed that the resident clinical records were not completed and or maintained accordingly.</p> <p>A review of the clinical record revealed Resident 60 was admitted to the facility on [DATE], with diagnoses to include polyneuropathies (damage/disease affecting the peripheral nerves featuring weakness, numbness and burning pain), autonomic neuropathy (damage to the nerves that control the automatic body functions such as blood pressure, temperature control, digestion, and bladder function), and anxiety.</p> <p>An Admission Minimum Data Set assessment (MDS-standardized assessment completed at specific intervals to identify specific resident care needs) dated April 29, 2024, indicated that the resident was cognitively intact with a BIMS (brief interview to assess cognitive status) score of 14 (13-15 represents cognitively intact responses).</p> <p>Review of a nurses note dated May 31, 2024, at 11:29 AM revealed the facility received a call from the resident's wife stating that she received a call regarding a referral that was made while the resident was in the hospital. The resident had a scheduled appointment with Psychology at [NAME] in Danville on July 1, 2024, at 12:25 PM. MD aware.</p> <p>A nurses note dated June 12, 2024, at 7:54 AM revealed a call was placed to the resident's wife to communicate that the facility was unable to accommodate transporting the resident to the [NAME] Psychology appointment on July 1, 2024, due to distance as per Administrator and DON (Director of Nursing). Message left.</p> <p>A nurses note dated June 12, 2024, at 12:00 PM revealed a call was received from the resident's wife acknowledging that the facility was unable to transport the resident. Wife stated she will call [NAME] Psychology to see if they will do a telehealth appointment.</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A nurses note dated July 12, 2024, at 1:18 PM revealed the facility spoke with the Psychology department at [NAME] and the receptionist stated the resident will login (for his appointment) through his MyChart login.</p> <p>During an interview with Resident 60 on July 23, 2024, at 11:50 AM, the resident stated that the facility was unable to transport him to the July 1, 2024, appointment so his wife and daughter drove him to his [NAME] Psychology appointment in Danville.</p> <p>A review of the resident's clinical record revealed no documented evidence that the resident had left the facility to attend the appointment on July 1, 2024, or the results of that appointment upon the resident's return to the facility.</p> <p>Continued interview with Resident 60 revealed that the resident had a telehealth visit on July 12, 2024. The resident expressed frustration that the facility did not provide an electronic device to conduct the visit and his daughter had to scramble to get my son to bring in a device.</p> <p>Further review of the resident's clinical record revealed no documented evidence that the resident had a scheduled telehealth visit and no documented evidence of the results of that visit.</p> <p>Interview with the Director of Nursing on July 25, 2024, at approximately 12:15 PM, confirmed there was no documented evidence the resident left and returned to the facility for an appointment on July 1, 2024, no documented evidence that the resident attended a telehealth visit on July 12, 2024, and no documented evidence of the outcome of those visits.</p> <p>28 Pa. Code 211.12 (c)(d)(1)(3)(5) Nursing services</p> <p>28 Pa. Code 211.5(f) Medical records</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  395625	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  07/25/2024
NAME OF PROVIDER OR SUPPLIER  Marywood Heights		STREET ADDRESS, CITY, STATE, ZIP CODE  2500 Adams Avenue Scranton, PA 18509	
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 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41460</b></p> <p>Based on clinical record review, observations, and staff interview, it was determined that the facility failed to maintain infection control practices to prevent potential spread of infection on one resident care unit out of two. (Second Floor).</p> <p>Findings include:</p> <p>Clinical record review revealed Resident 1 was admitted on [DATE], with diagnoses which included retention of urine, acute cystitis (sudden bacterial infection of the bladder or lower urinary tract) without hematuria (blood in urine), urinary tract infection ([UTI] an infection of the urinary system which includes the kidney, bladder, or urethra), and required the use of an indwelling catheter( a thin hollow tube inserted through the urethra into the urinary bladder to collect and drain urine) for urination.</p> <p>Review of clinical record revealed that on May 17, 2024, the resident had an appointment with Urology. Orders received from urology included to irrigate foley daily to prevent sediment buildup, irrigate as needed for decreased urinary output, maintain foley with changes every 4 weeks.</p> <p>Observation on July 23, 2024, at 11:30 AM, revealed an undated bulb piston syringe, and an undated, unlabeled, opened 1000mL bottle of sterile water with approximately 600mL remaining in the bottle setting on top of a 3-drawer cart in Resident 1's bathroom.</p> <p>Interview with Employee 1, licensed practical nurse (LPN), confirmed the observation on July 23, 2024, at approximately 11:45 AM. Employee 1 further confirmed that there was no evidence of how old the items were, that the items should have been labeled and dated, and that the items were not in a manner to prevent the potential spread of infection.</p> <p>During an interview with the Director of Nursing (DON), and in the presence of the Nursing Home Administrator (NHA) on July 25, 2024, at 1:30 p.m., confirmed that the facility failed to maintain resident care equipment in a manner to prevent the potential spread of infection.</p> <p>Refer F690</p> <p>28 Pa. Code 211.10(a)(c)(d) Resident care policies</p> <p>28 Pa. Code 211.12 (c)(d)(1)(5) Nursing services</p>		