STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395717	A. Building B. Wing	05/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Linwood Nursing and Rehabilitation Center	100 Florida Avenue Scranton, PA 18505

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43944 Based on review of clinical records, and staff interviews, it was determined that the facility failed to timely notify a resident's responsible representative of injuries sustained by one resident out of eight sampled (Resident A1). Findings include: 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 record to support the ability of the health care team to ensure informed decisions and high-quality care in the continuity of patient care: Assessments, Clinical problems, Communications with other health care professionals regarding the patient, Communication with and education of the patient, family, and the patient's designated support person and other third parties. A review of Resident A1's clinical record revealed that the resident was admitted to the facility on [DATE], with diagnoses that included chronic obstructive pulmonary disease [(COPD) is a common, preventable and treatable disease that is characterized by persistent respiratory symptoms like progressive breathlessness and cough], pulmonary fibrosis [is scarring and thickening of the tissue around and between the air sacs called alveoli in the lungs. These changes make it harder for oxygen to pass into the bloodstream], major depressive disorder, major anxiety disorder, and history of falls. A quarterly Minimum Data Set assessment (Minimum Data Set - a federally mandated standardized assessment conducted at specific intervals to plan resident care) dated March 4, 2024, revealed that the resident had moderate cognitive impairment. Resident A1's clinical record revealed a form for a change in condition completed by Employee 1, a licensed practical nurse (LPN), dated April 25, 2024, at 10:00 p.m., which noted that the resident sustained a skin tear on the lateral side of her lower left leg that measured 15 cm (centimeters) and the physician was notified with new treatment orders. There was no documented evidence that the resident's representative was notified of the resident's injury, a skin tear, sustained to her lateral left lower leg. (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A health status progress note completed by Employee 2, a LPN, dated April 30, 2024, 2:17 p.m., revealed that the resident was found to have a 3.5 cm x 6 cm purpura area [hemorrhages in the skin and mucous membranes that result in the appearance of purplish spots or patches] on her left arm and a 9.2 cm x 4.5 cm purpura area on her right arm. The resident was encouraged to wear and keep her Geri sleeves on as per order. The resident's son stated that he noticed the purpura areas on residents both arms on 4-25-24 when he was in to visit her. Resident A1's clinical record failed to reveal that the resident's representative was was timely notified of bruised areas of unknown origin to the resident's right and left arms, which the resident's son observed while visiting. An interview with the Director of Nursing (DON) on May 15, 2024, at 2:30 p.m., confirmed that the facility was unable to provide evidence that the facility had timely notified the resident's representative of the resident's injuries. 28 Pa Code 211.12 (c)(d)(3)(5) Nursing services 28 Pa. Code 201.29 (a) Resident rights

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43944 Based on a review of clinical records, select facility policy and fall reports and staff interview it was determined that the facility failed to consistently implement planned fall prevention interventions for a resident identified a high risk for falls for one resident out of eight sampled (Resident B1). Findings included: A review of Resident B1's clinical record revealed that the resident was admitted to the facility on [DATE], with diagnoses that included rhabdomyolysis [a breakdown of skeletal muscle due to direct or indirect muscle injury and left untreated can result in kidney damage], history of falling, and Alzheimer's disease [is a type of brain disorder that causes problems with memory, thinking and behavior. This is a gradually progressive condition]. A review of the resident's initial fall risk evaluation dated May 1, 2024, at 9:30 p.m., identified that the resident was a high fall risk related to falling 1-2 times over the last six-months, and never oriented to person, place, time, or situation, and occasional incontinence, decreased in muscle coordination, and requires hands-on assistance to move from place to place. The resident's care plan dated May 2, 2024, identified that Resident B1 was at risk for falls due to impaired mobility and a goal to prevent falls with injury. Planned interventions were to place all necessary personal items within reach while in bed, remind resident to use call light when attempting to ambulate or transfer, place call light within reach while in bed or close proximity to the bed, and monitor for signs/symptoms of anxiety and promote self-management strategies. The admission/5-day Minimum Data Set assessment (Minimum Data Set - a federally mandated standardized assessment conducted at specific intervals to plan resident care) dated March 4, 2024, revealed that the resident had moderate cognitive impairment. An incident report completed by Employee 4, a Registered Nurse (RN), on May 8, 2024, at 3:50 a.m., revealed that a nurse aide was sitting just outside of the resident's {Resident B1} room and had already completed rounds on resident, heard a thud, walked in, and observed resident lying on the floor next to his bed. I {Employee 4} was call to room and observed resident lying on his right side on the right side of the bed on the floor. Bed was in the lowest position; call bell was within easy reach of resident and non-skid socks were on both feet. Resident assisted back to bed and was unable to describe the incident. There was no evidence of unusual pain or discomfort while assessing resident. As fall was not witnessed, neuro checks were initiated and WNL (within normal limits) for resident. Attending physician was notified with NON (new orders noted) for padded mats on either side of bed while in bed, and to check placement every shift. Responsible party (RP) notified of incident. The fall investigation report concluded that the resident's slid off his low air loss mattress (pressure relief devise to manage pressure injuries) and interventions were revised for the placement of fall mats to both sides of the resident's bed. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An incident report revealed that the resident had another unwitnessed fall. The report, completed by Employee 5, a RN, dated May 14, 2024, at 9:58 a.m., revealed that this nurse was called to resident room post fall and found resident on floor, on right side of bed on his right side. Denied hitting his head. No hematoma noted. Awake and alert and ware of his name. He was at baseline cognitive impairment. Upon assessment found that vital signs and neuro checks were within normal limits. RLE (right lower extremity) appeared to be externally rotated. Pulses were palpable. MD and RP (son) made aware, and the resident was sent to the emergency department for an evaluation of his right lower extremity. A review of a post event staff interview statement from Employee 6, a nurse aide (NA), no date or time indicated, revealed that when walking down the hallway at approximately 9:15 a.m., the employee saw that the resident fell out of bed and was found on laying on his right side of the bed and on the right side of his body. I {Employee 6} laid him down for wound care and was not notified when he was done with care. No interventions were in place prior to the event. A post event staff interview statement from Employee 7, a LPN, dated May 14, 2024, no time noted, revealed that she was in the 400-hall performing wound care rounds and last saw the resident at 7:00 a.m. at the nurse's station. Nurse aide was asked to put Resident B1 back into bed for wound round. Resident was clean and dry, unaware if the floor mats were still on the floor. Last saw the resident at 8:50 a.m. with call bell in reach. The facility provided incident report investigation concluded that Resident B1's fall mats were not in place as planned to decrease the potential for injury as the result of falls from bed. A review of a health status progress note in the clinical record completed by Employee 5 on May 14, 2024, at 2:56 p.m., revealed that X -rays were completed on both hips and showed no fracture. Resident B1 was not admitted to the hospital and returned to the facility on [DATE], at 7:12 p.m. The facility failed to ensure that the planned safety measure, fall mats to each side of bed, were applied as planned. During an interview with the Director of Nursing (DON) on May 15, 2024, at 3:15 p.m., confirmed that Resident B1's planned fall interventions, fall mats, were not put back into place after wound care rounds. 28 Pa. Code 211.12 (c)(d)(1)(3)(5) Nursing services.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43944 Based on a review of clinical records and staff interview, it was determined that the facility failed to assure timely and completely documented clinical records, according to professional standards, for one of eight sampled residents (Resident A1). Findings include: 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 record to support the ability of the health care team to ensure informed decisions and high-quality care in the continuity of patient care: Assessments, Clinical problems, Communications with other health care professionals regarding the patient, Communication with and education of the patient, family, and the patient's designated support person and other third parties. A review of Resident A1's clinical record revealed that the resident was admitted to the facility on [DATE], with diagnoses that included chronic obstructive pulmonary disease [(COPD) is a common, preventable and treatable disease that is characterized by persistent respiratory symptoms like progressive breathlessness and cough], pulmonary fibrosis [is scarring and thickening of the tissue around and between the air sacs called alveoli in the lungs. These changes make it harder for oxygen to pass into the bloodstream], major depressive disorder, major anxiety disorder, and history of falls. A quarterly Minimum Data Set assessment (Minimum Data Set - a federally mandated standardized assessment conducted at specific intervals to plan resident care) dated March 4, 2024, revealed that the resident had moderate cognitive impairment. An incident report completed by Employee 3, Registered Nurse (RN) Supervisor, dated April 30, 2024, at 3:01 p.m., revealed that Resident A1 had an unwitnessed fall and was found by a nurse aide responded to the sounding alarm in the resident's room and found her on the floor. Employee 3 was in to see Resident A1 and observed that she was lying naked on her floor on her left side of her bed on the right side of her body, head down. Resident A1 could not describe the incident. Employee 3 assessed the resident to have a large hematoma on the right side of her forehead and a reddened area on her right hip with the resident offering complaints of head and right leg pain. The attending physician was called with new orders to transfer Resident A1 to the emergency department for an evaluation. Responsible party was notified of fall and transfer to the hospital. A progress note completed by Employee 2, an agency licensed practical nurse (LPN), dated April 30, 2024, at 7:45 p.m., revealed that a telephone call was placed to a hospital's emergency department Nurses station, resident had not been seen by a Physician yet. RN supervisor aware of same. A health status progress note completed by Employee 2 on May 1, 2024, at 1:53 p.m., indicated that Resident A1 was admitted to the hospital with a diagnosis of hematoma. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A progress note completed by Employee 2 on May 1, 2024, at 10:42 p.m., , which was not noted as a late entry, repeated the account of the resident's fall as noted in the incident report, but failed to include additional documentation of a thorough nursing assessment of the resident, to include detailed description of the resident's injuries, to include size and characteristics, results of any neurological assessment and vital signs, and level of pain voiced by the resident at the time of the fall on on April 30, at 3:01 p.m. Interview with the Director of Nursing (DON) on May 15, 2024, at 2:35 p.m., confirmed that the facility's licensed and professional nursing staff failed to timely and thoroughly document the circumstances surrounding the resident' unwitnessed fall and the post-fall assessment in the clinical record and that the record was inaccurate. 28 Pa. Code 211.12 (d)(3)(5) Nursing services. 28 Pa. Code 211.5 (f) Medical records.