

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395717	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/23/2024
NAME OF PROVIDER OR SUPPLIER Linwood Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. 13456 Based on observation, clinical record review, and resident and staff interview, it was determined that the facility failed to protect the personal privacy rights of one of six residents sampled (Resident 1). Findings include: During an observation of Resident 1's room on July 23, 2024 at approximately 10:15 AM a hand written sign was observed taped to the back of the resident's bed which read R Limb alert (RUE) NO IV, lab draws, BPs or tight clothing. Interview with Resident 1 and her daughter on July 23, 2024, at 10:20 AM revealed that they did not know why that sign was posted behind the resident's bed. They stated they did not put the sign there, the facility did. When asked Resident 1 stated there was no reason that they could not use her right arm. She stated no one ever mentioned to her that her right arm should not be used. Resident 1 then asked if the sign could be removed from the wall behind her bed. A review of the resident's clinical record indicated her right arm should not be used for blood draws, but did not identify the clinical reason or diagnosis. Interview with the Nursing Home Administrator (NHA) on July 23, 2024 at 3:00 PM revealed that the NHA was unable to provide information regarding the reason for this sign posted behind the resident's bed, that failed to assure the resident's personal privacy. 28 Pa. Code 201.29 (a) Resident rights		

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 13456 Based on observation, clinical record review and resident and staff interview, it was determined that the facility failed to ensure that a resident's comprehensive care plan included the care the resident required to attain the resident's highest practical physical well-being for one resident out of six reviewed (Resident 1). Findings including: Clinical record review revealed that Resident 1 was admitted to the facility on [DATE], with diagnoses to include a displaced fracture of the right lower leg (broken ankle) with history of falls. An interview and observation of Resident 1 at 10:00AM on July 23, 2024, revealed that the resident had a blue hard cast on her right leg, that extended from the base of her toes to just below her knee. A review of the resident's current plan of care initially, dated May 30, 2024, revealed that the presence of the cast or the need for assessment of her exposed toes to ensure that adequate color, circulation, sensation and mobility was present without swelling, was not included on the resident's care plan.		

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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** 13456 Based on review of clinical records and staff interview it was determined that the facility failed to provide nursing services consistent with professional standards of practice for one resident (Resident 1) out of six residents reviewed by failing to assure prompt and necessary treatment for treatment for a resident's complaints of physical discomfort, painful urination, which delayed diagnosis and treatment of a salmonella infection. Findings included: According to the Pennsylvania Code, Title 49, Professional and Vocational Standards, State Board of Nursing, 21.292a. CRNP (Certified Registered Nurse Practitioner) Practice (b)(1)(2) indicates (b) When acting in collaboration with a physician as set forth in a collaborative agreement and within the CRNP's specialty, a CRNP may: (1) Perform comprehensive assessments of patients and establish medical diagnoses. (2) Order, perform and supervise diagnostic tests for patients and, to the extent the interpretation of diagnostic tests is within the scope of the CRNP's specialty and consistent with the collaborative agreement, may interpret diagnostic tests. A review of clinical record revealed Resident 1 was admitted to the facility on [DATE], with diagnoses, of the fracture of right ankle, muscle weakness and high blood pressure. A review of an admission MDS (Minimum Data Set - a federally mandated standardized assessment conducted at specific intervals to plan resident care) dated June 4, 2024, revealed that Resident 1 was moderately cognitively impaired with a BIMS score of 11 (Brief Interview for Mental Status tool used to screen cognitive condition of residents) and required staff assistance with activities of daily living and had a history of falls. The resident had a cast to her right lower leg due to fractured ankle. During an interview with this resident conducted on July 23, 2024, at 10:00 AM the resident stated that a few weeks ago she starting having burning, pressure and discomfort when she urinated. She stated the CRNP (certified registered nurse practitioner) examined her and the CRNP informed the resident that she would test her urine. The resident stated that this urine test was not completed until several days after the CRNP visit with the resident, until the resident voiced a complaint to Employee 1, LPN, licensed practical nurse (LPN), who contacted the physician, obtained an order and a urine sample to test the resident's urine. During the interview, the resident stated that she very upset that the urine test was delayed, and treatment was not started for many days because she continued to have discomfort when urinating. (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the resident's clinical record revealed a note written by the CRNP dated July 8, 2024, which indicated that she spent 30 minutes with the resident assessing the resident and answering questions. The entry noted that the resident complained of dysuria (pain or burning sensation while passing urine) and the CRNP noted check UA C/S (Urinalysis culture and sensitivity urine test and urine culture is a method to grow and identify bacteria that may be in the urine. The sensitivity test helps select the best medicine to treat the infection). However, a review of physician orders revealed that the CRNP did not order a UA/C&S on this date. Documentation in the resident's clinical record dated July 13, 2024 written by Employee 1, LPN, at 3:55 PM indicated that a U/A C&S was obtained related to the resident's complaints of burning and pain with urination. This nurse's note was written late, the sample was obtained in the morning as indicated by the results. The courier service was contacted to pick up the sample. Interview with the resident on July 23, 2024, at 11 AM confirmed that it was Employee 1 who finally contacted the doctor obtain an order and get her urine sample. A review of the results of the resident's urine test, dated as reported July 17, 2024, at 1:52 PM revealed Salmonella (infection caused by salmonella bacteria that generally affects the intestinal tract, and occasionally the bloodstream and other organs due to eating or drinking contaminated food or water by contact with infected people or animals, or through contact with contaminated environmental sources) and Proteus Mirabilis (bacteria found in digestive tract). An antibiotic was ordered on July 18, 2024, Ampicillin 500 mg one capsule three times a day. The resident had a medication allergy and this antibiotic had to be changed to Ciprofloxacin 250 mg one tablet every 12 hours. The resident received her first dose of antibiotic treatment on July 18, 2024, at 5:13 PM, 10 days after the resident's complaint was made to the CRNP of the resident's pain during urination. Interview with Resident 1 on July 23, 2024 at 11:00 AM confirmed she waited days for treatment for her painful urination. She stated that Employee 1 finally listened to her and obtained an order for a urinalysis which identified the infection requiring treatment. The resident stated that she was very upset that she was admitted to the facility for therapy for a broken ankle and she ended up with a foodborne infection illness. The facility failed to timely address the resident's physical complaints. The resident made the CRNP aware of her complaints of dysuria on July 8, 2024, and recommended a UA C&S be completed, which was not obtained until five days later due to the resident's continued complaints. Treatment did not begin until July 18, 2024, ten days after the resident reported her complaints. During an interview on July 23, 2024, at approximately 3:00PM the NHA confirmed the resident was not timely treated for her infection. 28. Pa. Code 211.2 (d)(3)(5) Medical director. 28 Pa. Code 211.12 (c)(d)(1)(3)(5) Nursing Services		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 13456 Based on observation and staff interview, it was determined the facility failed to maintain an environment free of potential accident hazards on one of two floors (second floor). Findings include: Observation on July 23, 2024 from 9:00 AM through 2:30 PM the following: On the second floor unit residents were observed ambulating in the hallways and and self-propelling in wheelchairs. At this time two air purifier units were plugged into wall outlets on each side of the hallway near resident room [ROOM NUMBER] and 13. The units were not secured, and moveable and obstructed continued access to the handrails on that side of the corridor and also not secured in any manner to prevent tipping. The cords and plugs created a potential tripping hazard. A plastic container with three drawers was observed in the hallway near room [ROOM NUMBER], which contained rubber gloves, protective gowns and masks, obstructing access to the handrail An air purifier unit was observed plugged into the wall outlet in the 200 hallway near room [ROOM NUMBER], 300 hallway near 301 and 400 hallway near room [ROOM NUMBER] and 406. The units were not secured, and moveable and obstructed continued access to the handrails on that side of the corridor and also not secured in any manner to prevent tipping. The cords and plugs created a potential tripping hazard. Plastic containers with drawers were also located in the 300 hallway near resident room [ROOM NUMBER] and in the 400 hallway near room [ROOM NUMBER], obstructing access to the handrails. Interview the nursing home administrator (NHA) on July 23, 2024 at approximately 3:00 PM revealed the facility the air purifiers were placed in the corridors prior to her employment and agreed that the items positioned in the hallway impeded access to the handrails and created obstacles to residents' mobility in the hallways. 28 Pa. Code 201.18 (e)(2.1) Management		

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 13456 Based on a review clinical records and facility documentation and interviews with residents and staff it was determined that the facility failed to demonstrate that its quality assurance program fully investigated and analyzed causes of adverse events, a resident's diagnosed salmonella infection, to evaluate the adequacy of the facility's response to the foodborne illness and implement any applicable performance improvement activities. Findings included: Findings include: A review of the clinical record revealed that Resident 1 was admitted to the facility on [DATE], with a diagnosis of a fractured ankle. An interview with Resident 1 on July 23, 2024, at 10:00 AM revealed she had concerns with food served at the facility. She stated the food the food served was extremely salty. She stated that she received food items that she disliked, including soft cooked eggs, egg whites, baloney sandwiches and a variety of other foods prepared by the facility that were not to her liking. She stated she also received greasy silverware at meals. As a result, she stated that she decided she no longer wanted to eat the facility's food and requested her daughter to bring her food and meals to her at the facility. Resident 1 continued to explain during interview on July 23, 2024, at 11 AM that she began to have stomach discomfort and burning on urination and was seen by the CRNP (certified registered nurse practitioner) on July 8, 2024, who recommended a urinalysis with culture and sensitivity. Review of the clinical record revealed after a delay in obtaining the urinalysis, a result of Salmonella was reported to the facility on [DATE], and antibiotic treatment initiated for the resident July 18, 2024. A review of facility documentation dated July 19, 2024, revealed that Employee 2 a Registered Nurse (RN) relayed to a representative from the local district Community Health Department that this resident's daily meals are provided by her family. Continued interview with the resident on July 23, 2024, at 11 AM revealed that the resident stated that the facility informed she and her that the resident contracted the foodborne illness from the meals her daughter brought in to the facility. However, the resident stated that her daughter does not bring in all her meals and food and that she does consume some of the facility's food and beverages. Additionally, the facility did not evaluate staff practice in the dietary department and assure current awareness of food safety practices and that facility staff were following proper procedures to prevent foodborne illness such as proper handwashing, ensuring food is cooked to proper temperatures, fruits and vegetables washed or peeled properly, and ensuring milk and dairy products are pasteurized. (continued on next page)		

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility also did not evaluate the storage practices for the food the resident's daughter brings to the facility, including storage duration and appropriate temperatures. The facility did not provide any training or education regarding the prevention of foodborne illness for facility staff as a result of the salmonella infection. Interview with the Nursing Home Administrator on July 23, 2024 at 3:00 PM confirmed the facility did not initiate quality improvement activities in response to the resident's positive diagnosis of Salmonella and took no action internally, despite lack of evidence as to the conclusive source of the infection. The NHA stated that the facility did not consider the possibility that the facility was the potential source of the resident's infection. 28 Pa. Code 201.18 (e)(2)(3) Management		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 13456 Based on review of the facility's infection control tracking log and staff interview, it was determined the facility failed to maintain and implement a comprehensive program to monitor and prevent infections in the facility. Findings include: A review of the facility's policy entitled Infection Control Policies and Practices (not dated), conducted during the survey ending July 23, 2024, revealed that the facility's infection control policies are intended to facilitate maintaining a safe sanitary comfortable environment and help prevent and manage transmission of disease and infections. A review of the facility's infection control data provided during the survey of July 23, 2024, revealed that the facility's infection control program failed to reflect an operational system to monitor and investigate causes of infection and manner of spread. There was no evidence of a functional system, which enabled the facility to analyze clusters, changes in prevalent organisms, or increases in the rate of infection in a timely manner. A review of facility monthly infection control logs for June 2024 and July 2024, revealed the monthly line listing failed to consistently include the type of infection, pathogen, start date of antibiotic and length, precaution type and resolution date. The facility failed to demonstrate a functioning system for surveillance for routine, ongoing, and systematic collection, analysis, interpretation, and dissemination of surveillance data to identify infections (i.e., HAI and community-acquired), infection risks, communicable disease outbreaks, and to maintain or improve resident health status. The facility was unable to demonstrate how it tracks infections and addresses any areas needing corrective action. Resident 1 was diagnosed with Salmonella, a bacterial infection foodborne illness on July 17, 2024, revealed by a urinalysis from July 13, 2024. However, this infection was not included in the data and no plans for any intervention with staff and residents to deter similar infections. There was no indication that the limited data that was compiled was then evaluated to determine what could be done to prevent the spread or recurrence of infections within the facility. 28 Pa. Code 211.12 (c)(d)(5) Nursing services. 28 Pa. Code 211.10 (a)(d) Resident care policies		