| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 395717 | A. Building<br>B. Wing | 09/05/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Linwood Nursing and Rehabilitation Center | 100 Florida Avenue<br>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.

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| F 0583<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Keep residents' personal and medical records private and confidential.<br><br>41581<br><br>Based on observation and staff interview it was determined the facility failed to protect the personal privacy rights of three of 28 residents sampled (Resident A1, A2, and A3).<br><br>Findings include:<br><br>An observation of Resident A1's room on September 5, 2024, at 9:45 AM, revealed a sign was taped above the resident's bed indicating the resident was to have a Hoyer pad under her while in her wheelchair.<br><br>An observation of Resident A2's room on September 5, 2024, at 9:49 AM, revealed a sign was taped above the resident's bed indicating the resident is to have nectar thicken liquids only.<br><br>An observation of Resident A3's room on September 5, 2024, at approximately 9:55 AM revealed signs taped above the resident's bed indicating the resident was to have nectar thick fluids and no over the bed table.<br><br>Interview with the Nursing Home Administrator (NHA) on September 5, 2024, at approximately 5:15 PM revealed that the NHA was unable to provide information regarding the reason for these signs posted behind the residents' beds, that failed to assure the residents' personal privacy.<br><br>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 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26142<br><br>Based on review of clinical records and staff and resident interview, it was determined the facility failed to provide adequate supervision to prevent a fall and promote resident safety for two of 28 sampled (Resident's B1 and A 10).<br><br>Findings include:<br><br>A review of the clinical record revealed that Resident B1 was admitted to the facility on [DATE], with diagnoses to include cerebral infarction(stroke).<br><br>A review of an admission minimum data set assessment (Minimum Data Set - a federally mandated standardized assessment conducted at specific intervals to plan resident care) dated August 23, 2024 revealed the resident was cognitively intact, with a BIMS score ( Brief Interview for Mental Status. The BIMS test is used to get a quick snapshot of how well you are functioning cognitively at the moment.) of 15 ( a score of 13 to 15 indicates cognitively intact) and required staff assistance for transferring and toileting.<br><br>A review of a facility investigation report dated September 1, 2024 at 8:00 PM revealed staff was alerted to Resident B1's room by the resident shouting for help. Resident B1 was noted to be lying on his back on the floor of his bathroom with his head by the door and feet underneath the sink. The resident stated that he rang his call bell for over 20 minutes and really needed to use the bathroom to have a bowel movement.<br><br>Although Resident B1 required assistance with toileting, he wheeled himself into the bathroom and self transferred himself to the toilet. The resident stood up from the toilet to pull up his pants, and lost his balance and fell . Staff transferred him back to bed. Nursing assessed him and a small scrape was noted to his right elbow.<br><br>A review of a witness statement dated September 1, 2024 (no time indicated), Employee E5 (LPN) stated, at the time of the incident she and a nurse aide were caring for another resident who required the assistance of two staff members. Employee 5 was alerted by Resident B1 shouting for help from his room. Employee 5 indicated the resident was found lying on the bathroom floor. The resident told Employee 5 he had been ringing his call bell for 20 minutes and he really needed to use the bathroom to defecate.<br><br>A review of a witness statement dated September 1, 2024 (no time indicated), Employee E6 (nurse aide) stated she and the LPN were the only staff on duty at the time of the fall. They were caring for another resident who required the assistance of two staff members at the time of Resident B1's fall and they were not available to answer his call bell.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an interview September 5, 2024 at 1:00 PM, Resident B1 stated that on the date of his fall he rang his call bell for at least 20 minutes prior to his self transfer to the toilet. He stated he really needed to use the bathroom and could not wait any longer for staff assistance. He stated that he got himself onto the toilet then stood up. He attempted to pull up his pants, lost his balance and fell to the floor. He stated that he yelled for help for at least 25 minutes waiting for staff assistance to get off the floor. He stated that he was not happy that there was not sufficient staff working on his floor at the time of his fall.<br><br>There was one LPN and one nurse aide present on the floor at the time of this resident's fall. The unit had other residents who required the assistance of two staff members which did not allow them to answer call bells in a timely manner if they were assisting other residents.<br><br>There was no evidence at the time of the survey that Resident B1 received timely staff assistance to prevent a fall.<br><br>Clinical record review revealed that Resident A10 was admitted to the facility on [DATE] with diagnosis to include cerebral vascular accident (stroke) and hemiplegia/hemiparesis (one sided weakness of the body).<br><br>A quarterly MDS assessment dated [DATE] revealed the resident was cognitively intact with a BIMS score of 15 and required the assistance of staff for activities of daily living including transferring and toileting.<br><br>A review of the resident's current care plan indicated the resident was at risk for falls and had previous fall with interventions to include anti roll back devices to wheelchair to prevent tipping, non skid footwear, bed in the lowest position and bed and chair alarms to alert staff of unsafe transfers.<br><br>A review of a facility incident investigation dated September 3, 2024 at 6:15 PM revealed, nursing staff was alerted by another resident to come to Resident A 10's room. Resident A 10 was found on the floor. A bump with a small abrasion and edema (swelling) was noted above the left eyebrow. Neuro checks were initiated. The resident complained of a headache. The resident was transferred to bed. The Physician was contacted and the resident was sent to the emergency room for evaluation.<br><br>Hospital documentation dated September 3, 2024 indicated the resident had a CT (CT scan uses computers and rotating X-ray machines to create cross-sectional images of the body) of the head indicating a hematoma ( a collection of blood). The resident was examined and returned to the facility.<br><br>A review of a witness statement dated September 4, 2024 (no time indicated), Employee E7 (nurse aide) stated that Resident A10 was seated in her wheelchair in her room waiting for her dinner tray. Another resident (not identified in the incident investigation or clinical documentation) alerted staff that Resident A10 was on the floor. At approximately 5:45 PM prior to dinner tray arrival, she was in her wheelchair. Employee 7 indicated she had toileted the resident and placed her in front of her tray table with her meal.<br><br>The call bell system in the facility was not operational at the time of the fall and it could not be determined if the resident had a method of alerting staff of her needs at the time of the fall.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | An interview with the Nursing Home Administrator on September 5, 2024, at approximately 2:00 PM, confirmed the facility failed to provide evidence the staff provided timely assistance to prevent Resident B1's fall and confirmed the call bell system was not operational at the time of Resident A10's fall.<br><br>28 Pa. Code 201.18 (e)(2.1) Management<br><br>28 Pa. Code 211.12 (c)(d)(1)(3)(5) Nursing services |

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| F 0725<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26142<br><br>Based on a review of clinical records, review of facility documentation and interviews with staff and residents it was determined the facility failed to efficiently deploy sufficient nursing staff to provide timely and quality care to each resident including one residents out of 28 sampled (Resident B1).<br><br>Findings include:<br><br>A review of the clinical record revealed that Resident B1 was admitted to the facility on [DATE], with diagnoses to include cerebral infarction(stroke).<br><br>A review of an admission minimum data set assessment (Minimum Data Set - a federally mandated standardized assessment conducted at specific intervals to plan resident care) dated August 23, 2024 revealed the resident was cognitively intact, with a BIMS score of 15 ( Brief Interview for Mental Status. The BIMS test is used to get a quick snapshot of how well you are functioning cognitively at the moment a score of 13 to 15 indicates cognitively intact) and required staff assistance for transferring and toileting.<br><br>A review of a facility investigation report dated September 1, 2024 at 8:00 PM revealed staff was alerted to Resident B1's room by the resident shouting for help. Resident B1 was noted to be lying on his back on the floor of his bathroom with his head by the door and feet underneath the sink. The resident stated that he rang his call bell for over 20 minutes and really needed to use the bathroom to have a bowel movement.<br><br>Although Resident B1 required assistance with toileting, he wheeled himself into the bathroom and self transferred himself to the toilet. The resident stood up from the toilet to pull up his pants, and lost his balance and fell . Staff transferred him back to bed. Nursing assessed him and a small scrape was noted to his right elbow.<br><br>A review of a witness statement dated September 1, 2024 (no time indicated), Employee E5 (LPN) stated, at the time of the incident she and a nurse aide were caring for another resident who required the assistance of two staff members. Employee 5 was alerted by Resident B1 shouting for help from his room. Employee 5 indicated the resident was found lying on the bathroom floor. The resident told Employee 5 he had been ringing his call bell for 20 minutes and he really needed to use the bathroom.<br><br>A review of a witness statement dated September 1, 2024 (no time indicated), Employee E6 (nurse aide) stated she and the LPN were the only staff on duty at the time of the fall. They were caring for another resident who required the assistance of two staff members at the time of Resident B1's fall and they were not available to answer his call bell.<br><br>(continued on next page) |

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| F 0725<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview September 5, 2024 at 1:00 PM, Resident B1 stated that on the date of his fall he rang his call bell for at least 20 minutes prior to his self transfer to the toilet. He stated he really needed to use the bathroom and could not wait any longer for staff assistance. He stated that he got himself onto the toilet then stood up. He attempted to pull up his pants, lost his balance and fell to the floor. He stated that he yelled for help for at least 25 minutes waiting for staff assistance to get off the floor. He stated that he was not happy that there was not sufficient staff working on his floor at the time of his fall.<br><br>There was one LPN and one nurse aide present on the unit at the time of this resident's fall. The unit had other residents who required the assistance of two staff members which did not allow them to answer call bells in a timely manner if they were assisting other residents.<br><br>There was no evidence at the time of the survey that Resident B1 received timely staff assistance to the bathroom and to prevent a fall.<br><br>A review of a facility staffing records dated September 1, 2024 revealed that on the 3:00 PM to 11:00 PM shift the resident census on the short stay unit was 17 residents. Facility staffing documentation revealed that one LPN and one nurse aide were working on that unit at that time. Nurse aide staffing for the facility on the evening shift on this date failed to meet the minimum of 8.09 nurse aides for a facility census of 89. Staffing on this date for nurse aides was 7.06.<br><br>During an interview September 5, 2024 at 2 P.M., the Director of Nursing confirmed that staffing was not sufficient at the time of the resident's fall to timely answer his call bell and offer assistance to have potentially prevented the fall. The facility failed to deploy sufficient nursing staff in a manner to provide quality care and services to residents.<br><br>28 Pa. Code 211.12 (c)(d)(4)(5)(f.1)(3) Nursing services<br><br>28 Pa. Code 201.18 (b)(1)(3)(e)(1) Management |

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| F 0732<br><br>Level of Harm - Potential for minimal harm<br><br>Residents Affected - Many | Post nurse staffing information every day.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26142<br><br>Based on observation and staff interview, it was determined the facility failed to correctly post nurse staffing information.<br><br>Findings include:<br><br>Observation upon entrance to the facility on [DATE] at 9:00 AM and 11:56 AM. revealed the posted nursing time was dated September 5, 2024. The form displayed the resident census however, it did not include the staffing for the day that reflected the number of staff and hours worked by the nursing staff.<br><br>During an interview September 5, 2024 at approximately 1:00 PM, the Nursing Home Administrator confirmed the posted nursing time was not posted at the beginning of the shift. The facility failed to list the total number of staff and actual hours worked by the staff.<br><br>28 Pa.Code 201.18 (b)(3)<br><br>28 Pa. Code: 211.12 (d) Nursing Services |

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| F 0867<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41581<br><br>Based on a review of the facility's plan of correction from the survey ending July 23, 2024, the outcome of the activities of the facility's quality assurance committee, observations and interviews it was determined the facility's procedures failed to effectively identify ongoing deficient practices related to personal privacy and infection control.<br><br>Findings include:<br><br>As a result of the deficiencies cited under the requirements related to personal privacy, accident hazards infection control, and facility staffing during the survey of September 5, 2024, the facility developed a plan of correction to serve as their allegation of compliance, which included a quality assurance monitoring component to ensure that solutions were sustained. This corrective plan was to be completed and functional by August 12, 2024.<br><br>However, during the survey ending September 5, 2024, continuing deficient facility practice was identified with these same requirements.<br><br>According to the facility's plan of correction for the deficiency cited on July 23, 2024, relating to procedures to promote privacy to include, a House audit (of signs posted in resident rooms with personal information) completed August 12, 2024, re-education provided to nursing staff on policy's and procedures related Resident's Personal Privacy, nursing home administrator or designee will conduct facility environmental audits weekly times 4 then monthly times 2 and findings and outcomes will be reported at monthly Quality Assurance committee meeting.<br><br>At the time survey ending September 5, 2024, the following observations were made:<br><br>Resident A1's room on September 5, 2024, at 9:45 AM, revealed a sign taped above the resident's bed indicating the resident was to have a Hoyer pad (indicated assistance needed for transfers) under her while in her wheelchair.<br><br>Resident A 2' s' room on September 5, 2024, at 9:49 AM, revealed a sign taped above the resident's bed indicating the resident is to have nectar thicken liquids (indication of swallowing issues) only.<br><br>Resident A3's room on September 5, 2024, at approximately 9:55 AM revealed signs taped above the resident's bed indicating the resident was to have nectar thick fluids (indication of swallowing issues) and no over the bed table.<br><br>The above noted observations failed to ensure the plan of correction was implemented in regard to resident privacy.<br><br>(continued on next page) |

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| F 0867<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | According to the facility's plan of correction for the deficiency cited on July 23, 2024, relating to the infection control program, the facility Infection Control program was re-evaluated for any outstanding infection control needs, including but not limited to monitoring and investigating causes and manner of spread.<br><br>A facility wide audit was ongoing for any outstanding or new infection control needs.<br><br>Policy reviewed by Quality assurance team. Monthly Infection Control log line listing verified it must include type of infection, pathogen, start date of antibiotic and length, precaution type and resolution date.<br><br>Infection control nursing, nurse management and general nursing staff re-educated on the facilities policy and procedure for infection control.<br><br>Facility wide audit education provided to staff on policy entitled Infection Control Policy and procedure.<br><br>Infection Control Nurse/Designee will complete weekly audits times 4 weeks then monthly times 2 and report findings at QA meeting.<br><br>A review of the facility's infection control data provided during the survey of September 5, 2024, revealed the facility's infection control program failed to reflect an operational system to monitor and investigate causes of infection and the 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.<br><br>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 healthcare aquired infections 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.<br><br>Resident A 9 was diagnosed with Rhinovirus infection (upper respiratory infection) and pneumonia after presenting with a persistent cough and was sent to the hospital for evaluation on September 1, 2024 at 7:12 PM. The resident returned to the facility on [DATE] at 12:31 AM with physician orders for Prednisone 20 mg (a steroid medication to decrease inflammation )once daily for five days, and Amoxicillin-Potassium Clavulanate 875-125 mg (an antibiotic medication) twice daily for ten days<br><br>This infection was not included in the data and no plans for any intervention with staff and residents to deter similar infections.<br><br>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.<br><br>Observations on September 5, 2024 at 9 AM and at 11:30 AM, Resident 7 was observed sitting in his wheelchair with his catheter (plastic tube in the bladder to drain urine) bag, containing urine lying next to him directly on the floor.<br><br>(continued on next page) |

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| F 0867<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | An observation of the bathroom in room [ROOM NUMBER] on September 5, 2024 at 11 AM revealed an uncovered bed pan with a wash basin inside of it, directly on the floor.<br><br>Items stored directly o the floor have the possibility to increase the risk of transmission of infection.<br><br>The acility failed to maintain a complete and accurate infection control program as well as ensure infection control practices to promote infection control in the facility.<br><br>An interview with the Nursing Home Administrator (NHA), on September 5, 2024, at approximately 2:00 PM, indicated her expectation was that there were no signs posted on resident walls, infection control monthly logs and tracking as well as infection control practices are maintained, fall prevention is maintained, and confirmed the facility's quality assurance plan was ineffective in identifying, investigating, these continuing areas of deficient practice and its corrective plan failed to prevent recurrence of similar quality deficiencies in the areas of procedures to promote resident privacy, fall prevention and infection control .<br><br>Refer F583, F689, F880<br><br>28 Pa. Code 211.12 (c)(d)(3) Nursing services<br><br>28 Pa. Code 201.18(e)(1) Management. |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide and implement an infection prevention and control program.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26142<br><br>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 and failed to maintain infection control practices to prevent the spread of infections regarding foley catheter maintance for 1 of 28 sampled residents. (Resident 7).<br><br>Findings include:<br><br>A review of the facility's policy entitled Infection Control Policies and Practices (not dated), conducted during the survey ending September 5, 2024, revealed 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 infection.<br><br>A review of the facility's infection control data provided during the survey of September 5, 2024, revealed the facility's infection control program failed to reflect an operational system to monitor and investigate causes of infection and the 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.<br><br>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-healthcare associated infections 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 address any areas needing corrective action.<br><br>Nursing documentation dated August 25, 2024 at 5:22 PM indicated Resident A 9' s' daughter was concerned with her mother's continued coughing. It was noted that Tessalon (cough medicine) was given per physician orders. On August 30, 2024 at 2:00 PM, the resident was noted with a persistent cough. The Physician was contacted and a chest X-Ray was ordered and completed with no illness identified. On August 31, 2024 at 10:55 PM, the resident was noted with increasing coughing on the shift. Cough medicine was administered with no effect. Her lungs were noted with wheezes, bilaterally. The Physician was again notified of the residents symptoms.<br><br>Nursing documentation dated September 1,2024 7:12 PM revealed the chest x-ray results were received and sent to the physician along with a report of the resident's worsening productive cough with wheezing. The Physician ordered the resident sent to the emergency room for evaluation.<br><br>Hospital documentation dated September 1, 2024 indicated the resident was diagnosed with Rhinovirus infection (upper respiratory infection) and pneumonia of right lower lobe She was prescribed Prednisone 20 mg (a steroid medication to decrease inflammation )once daily for five days, and Amoxicillin-Potassium Clavulanate 875-125 mg (an antibiotic medication) twice daily for ten days. The resident returned to the facility on [DATE] at 12 :31 AM.<br><br>This infection was not included in the data and no plans for any intervention with staff and residents to deter similar infections.<br><br>(continued on next page) |

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| | 395717 | A. Building<br>B. Wing | 09/05/2024 |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | There was no indication 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.<br><br>An observation September 5, 2024 at 11 AM in resident bathroom [ROOM NUMBER], there was an unbagged bed pan with an unbagged resident wash basin inside on the floor next to the toilet.<br><br>An observation September 5, 2024 at 9 AM and again at 11:30 AM Resident 7 was seated in his wheelchair with his foley catheter bag directly on the floor.<br><br>An interview September 5, 2024 at approximately 1:00 PM, the facility infection Preventionist (IP) stated she just became the Infection Preventionist in the facility in the past month. She confirmed the infection logs were not complete and infection control practices should be maintained in the facility.<br><br>28 Pa. Code 211.12 (c)(d)(5) Nursing services.<br><br>28 Pa. Code 211.10 (a)(d) Resident care policies |

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| F 0919<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | Make sure that a working call system is available in each resident's bathroom and bathing area.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41581<br><br>Based on observations, a review of facility documentation, clinical record review, and resident and staff interviews, it was determined the facility failed to ensure the call bell system was adequately equipped to allow residents to call for staff assistance, by failing to ensure the call bell system was fully functional in three (100, 200 and 300) out of the four areas of the facility. The facility failed to identify the risks and safety of the residents who need to utilize their call bell for staff assistance placing the residents in an Immediate Jeopardy situation.<br><br>Findings include:<br><br>A review of a facility documentation dated September 3, 2024, revealed on August 31, 2024, at approximately 7:00 PM the facility experienced a possible lightning strike causing the call bell alert system to malfunction. Upon the building assessment, it was noted the call bell system was not functioning in the 100, 200, and 300 Halls of the resident units. Further it was indicated the residents were provided tap call bells (non computerized device that when tapped by a resident a bell sounds, this sound cannot be heard throughout the facility or over long distances) which were placed in their rooms and facility staff would complete safety checks. This was the plan upon identification of the non functioning call bell system.<br><br>An interview with Employee E4, maintenance director, on September 5, 2024, at approximately 10:40 AM revealed he was called into the facility on [DATE], due to the call bell system not working. The employee stated at around 8:00 PM the contracted company for the call bell system came to the facility to assess the call bell system. The employee stated the contracted company went through the system and identified the server was down and the 100, 200, 300, and 400 halls with the exception of rooms 408, 409, 411, and 412, call bells were nonfunctional. The Employee E4 was informed that technicians would be back out to the facility during the week. At that time the employee indicated he retrieved tap bells and gave them to the nursing supervisor who was on duty. The employee stated he did not know if there was enough call bells for all the residents who did not have a functioning call bell. Furthermore, Employee E4 stated on Tuesday September 3, 2024, two technicians were in the building to diagnose the call bell system. At that time the technicians identified system devices were shorted and the server and hard drives were bad. They suggested at that time the whole system will need to be replaced. Employee 4 stated he had not heard anything further about when the system will be replaced.<br><br>Observations of the 100 Hall on September 5, 2024, at approximately 11:00 AM revealed the call bells system in the hall were not functioning. The call bells were not lighting up or sounding when the call bells were activated (button pressed by a resident to alert staff of the need for assistance) in the resident bedrooms and bathrooms. Further observations on the 100 Hall revealed Resident A4 did not have a tap bell in her room to ring for staff assistance.<br><br>Observations of the 200 Hall on September 5, 2024, at approximately 11:05 AM revealed the call bell system in the hall were not functioning The call bells were not lighting up or sounding when the call bells were activated in the resident bedrooms and bathrooms.<br><br>(continued on next page) |

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| F 0919<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | An interview with Employee E1 Agency NA (nurse aide) on September 5, 2024, at 11:08 AM indicated the employee stated she was never educated on how often frequent rounding (intentionally checking and visualizing residents at regular intervals) and safety checks were to be completed, but she rounds (observes) the residents every two hours. When asked if all residents had tap bells the employee indicated that not all residents had tap bells to use. Furthermore, the employee was asked how they would know if a resident needed assistance in the bathroom since there were nonfunctioning call bells in the bathroom, the employee stated she would just go check on the resident but doesn't know how the residents could alert the staff.<br><br>An interview with Employee E2 RN (registered nurse) on September 5, 2024, at 11:12 AM revealed the call bell system has not been functioning and the residents were to use tap bells. The employee stated they do resident rounding every two hours but have not been told to increase the rounding due to the nonfunctioning call bell system. When asked how they would know if a resident needed help in the bathroom, she stated the staff should be bringing them into the bathroom and staying with them, but if resident's go to the bathroom by themselves, they should bring their tap bell in with them. When asked if residents were educated to do so, the employee stated she didn't know.<br><br>An interview with Employee E3 NA on September 5, 2024, at approximately 11:15 AM indicated she does resident rounding every 2 hours. The employee stated she was not told she had to do more frequent rounding since the call bell system was not functioning. The employee indicated that everyone should have a tap bell but not all residents know how to use them. When asked how she would know if someone needed help, that was unable to use the bell, or if a resident was in the bathroom where no bells were accessible, the employee stated I guess I would just hear them yell out.<br><br>Observations of the 300 Hall on September 5, 2024, at approximately 11:20 AM revealed the call bells in the hall were not functioning. The call bells were not lighting up or sounding when the call bells were activated in the resident bedrooms and bathrooms. Further observations revealed Resident A5, Resident A6, and Resident A7 did not have tap bells in their rooms to ring for staff assistance.<br><br>An interview with Resident A8 on September 5, 2024, at the time of the observations on the 300 Hall indicated the resident stated when you hit the tap bell the staff do not know where it is coming from. The resident indicated he would just have to wait for staff's assistance until they figured out who was ringing the tap bell. Furthermore the resident indicated, since the call bell was not working in the bathroom, he would just have to yell out for help until someone hopefully heard him to arrive to assist him.<br><br>An observation of Resident A9 on September 5, 2024, at approximately 11:30 AM revealed the resident was in her room in the bathroom. The resident was retching and spitting up mucus in the toilet. The resident appeared upset and moaning at times while coughing and retching. The resident indicated she wheeled herself to the bathroom because her stomach was bothering her, and she was coughing up mucus. The resident stated she needs help but doesn't know how to get the staff's attention to help her since the call bell system doesn't work. The resident pointed to the call bell on the wall in the bathroom and stated it was broken.<br><br>(continued on next page) |

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| F 0919<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | A review of Resident A10's clinical record revealed the resident was admitted to the facility on [DATE], with diagnoses which included hemiplegia (paralysis on one side of the body) and hemiparesis (weakness on one side of the body) affecting the left side and seizure disorder. A review of quarterly MDS (minimum data set- a federally mandated standardized assessment conducted at specific intervals to plan resident care) dated August 3, 2024. The resident is cognitively intact with a BIMS of 15 (13 (brief interview for mental status, a tool to assess the residents attention, orientation and ability to register and recall new information, a score of 13-15 equates to being cognitively intact). The resident was able to ring her call bell for assistance if needed.<br><br>A review of the resident's plan of care initially dated April 19, 2023, indicated the resident is non compliant with safety interventions and has poor safety awareness. The resident's care plan dated April 22, 2023 indicated to place the call light within her reach and educate on the importance of using the call bell for assistance.<br><br>A review of a progress note dated September 3, 2024, at 7:22 PM revealed staff had to be alerted by another resident that Resident A10 was lying on the floor in her bedroom. The resident was found lying on her back with her head towards the bedroom door. The resident's call bell was not functional and resident could not ring bell for assistance to transfer or to be helped off the floor. The resident was noted to have a lump and abrasion above her right eyebrow. The resident was complaining of a headache at that time. The resident was sent out to the hospital for further evaluation.<br><br>An interview with the Nursing Home Administrator (NHA) on September 5, 2024, 2024, at approximately 12:24 PM revealed when the call bells system became inoperable, the staff were alerted to do frequent rounding or make frequent observations of residents to anticipate their need for care. When asked what frequent rounding meant, the NHA stated the standard every two hours. When asked how the facility was tracking that frequent rounds were being completed, the NHA indicated the supervisor would sign a paper that the rounding was completed every shift. The NHA was asked how the supervisors would know if the observations were completed in order to sign off indicating the observations were completed, if they were not the ones doing the rounding. The NHA stated they would ask the staff if it was completed. The facility could not provide documentation completed by the staff that were actually doing the frequent rounding to assure rounding was completed. When asked how residents would alert staff if they needed assistance while in the bathroom, the NHA stated the staff would take them into the bathroom. The NHA was questioned regarding independent residents who are able to take themselves to the bathroom, if they required assistance how would stff be alerted? The NHA could not answer the question and stated there are no working call bells in the bathrooms and no residents should be going to the bathroom independently.<br><br>Immediate Jeopardy was called on September 5, 2024, due to the facility's failure to timely identify the health and safety of the residents due to the facility not having a functioning call bell system to alert staff when the residents needed assistance beginning on August 31, 2024 at 7:00 PM when the facility's call bell system became inoperable.<br><br>The facility was notified of the Immediate Jeopardy on September 5, 2024, at 1:15 PM and the IJ template was provided to the facility.<br><br>An immediate plan of correction was requested and received on September 5, 2024.<br><br>The plan included:<br><br>(continued on next page) |

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| F 0919<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | 1. Clip alarms will be placed in all bathrooms, shower rooms, and lobby visitor bathrooms with signs that say please pull string for assistance. All cognitively aware residents will be educated on the temporary call bell system and its purpose.<br><br>2. The call bell system quote and proposal will be signed by the NHA for repair of the call bell system<br><br>3. A full house facility audit will be completed to ensure all residents have tap bells in their rooms.<br><br>4. The facility will educate all staff on the 7am to 3pm, 3pm to 11pm, and 11pm to 7am shifts on the temporary call bell system and hall monitoring system. All staff on shift will be educated by September 5, 2024. All other nonscheduled staff and as needed staff will be educated on the temporary call bell system and hall monitoring system prior to the beginning of their next scheduled shift.<br><br>Following verification of the implementation of the corrective action plan, a tour of the facility and inspection of the supervision, the Immediate Jeopardy was lifted at on September 5, 2024, at 4:55 PM.<br><br>28 Pa. Code 201.18 (b)(1) Management<br><br>205.67(j) Electric requirements for existing construction.<br><br>28 Pa. Code 211.12(d)(5) Nursing Services. |