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	01/15/2025

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39929 Based on a review of clinical records, the facility's abuse prohibition policy, information provided by the facility, and staff interviews, it was determined that the facility failed to promptly conduct a thorough investigation to rule out abuse and implement corrective action for one of 6 residents reviewed (Resident 4). Findings included: A facility policy entitled Allegation, Suspicion, or Witnessed Abuse, Neglect, Misapplication, or Exploitation Intervention and Reporting, last reviewed by the facility on May 10, 2024, indicated that staff will immediately report the incident to the Charge Nurse or immediate supervisor of the area. Upon receiving a report of abuse or alleged abuse, the Charge Nurse or supervisor or the area shall immediately notify the RN Supervisor, who will respond to the location, examine the resident, and begin the investigation. The following information should be included in the initial verbal and subsequent written report: name of the resident(s) involved, the date and time of the incident, the exact location of the incident, the name(s) of the alleged perpetrator and contact information, the name(s) of any witnesses to the incident and contact information, a statement will be obtained from the resident(s) if he/she are interviewable (The RN Supervisor and/or Social Service will interview the resident) a description of the incident as witnessed, and any other pertinent information which may be useful to the investigation. The RN Supervisor will notify the appropriate personnel of the incident and shall include, but not limited to the following: Director of Nursing (DON) or Assistant Director of Nursing (ADON) immediately, Administrator (NHA) immediately, attending physician or as directed by the NHA, DON, or ADON (e.g., next day, if immediate notification is not warranted based upon the allegation, signs of injury, time, and type of allegation made), Resident Representation (RP) immediately or as directed by the NHA, DON, ADON (e.g., next day if immediate notification is not warranted based upon the allegation, signs of injury, time, and type of allegation made). (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 4's clinical record revealed the Resident was admitted to the facility on [DATE], with diagnoses that included adjustment disorder with anxiety (a mental and behavioral disorder defined by a maladaptive response to a psychosocial stressor. The maladaptive response usually involves otherwise normal emotional and behavioral reactions that manifest more intensely than usual, considering contextual and cultural factors, causing marked distress, preoccupation with the stressor and its consequences, and functional impairment). A significant change Minimum Data Set assessment (Minimum Data Set - a federally mandated standardized assessment conducted at specific intervals to plan resident care) dated January 10, 2025, indicated that the Resident was cognitively intact, with a BIMS (brief interview for mental status - a tool to assess cognitive status) of 13 (a score of 13 to 15 indicates intact cognition). Review of a report submitted to the state survey agency dated January 08, 2025, at 2:00 p.m., revealed that on that date and time Resident 4 disclosed to the social worker That a nurse aid had been rough with her during the night shift. The resident reported the nurse aide grabbed my foot and hurt it and later held her shoulders down. Resident 4 stated that she told her Go ahead and push me off the bed then I get two more weeks of therapy. The resident described the aide as a white stocky girl with light colored hair. The resident was assessed with no injuries noted. Upon request from this surveyor on January 15, 2025, at approximately 9:30 a.m., the Director of Nursing was unable to provide evidence of a completed investigation to review regarding this allegation made by Resident 4. While staff schedules were reviewed, no written statements from staff on duty on January 8th, 2025, were collected, and no interviews were conducted with other alert and oriented residents. Resident 4's clinical record contained no documentation related to the incident. During an interview on January 15th, 2025, at approximately 12:00 PM, the DON confirmed that staff working on the night of January 8th, 2025, were not interviewed regarding the alleged physical abuse and no documented evidence of a thorough investigation was available. An interview with the DON on January 15, 2025, at approximately 1:30 PM, confirmed the facility did not complete or document a thorough investigation into the alleged physical abuse. The facility failed to promptly and thoroughly investigate an allegation of abuse as required by the facility policy. 28 Pa. Code 201.14 (c) Responsibility of licensee. 28 Pa. Code 201.18 (b)(1) Management. 28 Pa. Code 201.29 (a) Resident rights.