

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  09/23/2025
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)
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for 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> Based on a review of clinical records, select facility policy, observations, and staff interviews, it was determined the facility failed to ensure the resident environment was free from potential accident hazards for one out of four nursing units observed (300 Hall), including observations made of one out of 14 residents' rooms (Resident 1). Findings included: A review of facility policy titled Medication Administration Practice Recommendations, last reviewed by the facility on August 14, 2025, revealed it is facility policy that a nurse or qualified staff should stay with the resident until medication has been taken. A clinical record review revealed Resident 1 was admitted to the facility on [DATE], with diagnoses that included chronic kidney disease (gradual loss of kidney function). A physician's order for Tylenol tablet 325 mg (acetaminophen-a pain-relieving medication) with directions to give two tablets by mouth every four hours as needed for mild pain was initiated on April 2, 2025. A physician's order for cranberry oral tablet 300 mg, with directions to give one tablet by mouth two times a day for frequent urinary tract infections, initiated on April 16, 2025. A physician's order for oxycodone HCl (hydrochloride) oral tablet 5.0 mg (oxycodone is a schedule II opiate narcotic medication; the United States Drug Enforcement Administration indicates schedule II drugs are defined as drugs with a high potential for abuse, with use potentially leading to severe psychological or physical dependence; these drugs are also considered dangerous) with directions to administer 5.0 mg by mouth one time a day for chronic pain initiated on May 26, 2025. A clinical record review revealed an evaluation titled Medication Self-Administration Safety Evaluation-CHR (11-2012), dated July 27, 2025. The evaluation indicated Resident 1 was not determined to be safe to self-administer medications. The evaluation documented that Resident 1 required nursing assistance with medication administration and could not state the purpose of each medication, the proper dosage, or the time the medication was to be taken. The evaluation also directed that medications were to be maintained by the nursing department and administered per facility staff. An observation conducted on September 23, 2025, at 9:23 AM, in Resident 1's room revealed five small clear plastic cups on the bedside table, containing a total of seven tablets and two capsules. The medications were unsecured and accessible in an open resident room, allowing potential access by other residents. The presence of multiple medications at the bedside created the risk of accidental consumption by other residents and the risk of Resident 1 consuming medications outside of prescribed parameters. During an interview on September 23, 2025, at 10:30 AM, the Director of Nursing (DON) confirmed the medications observed included six Tylenol 325 mg tablets, one cranberry 300 mg tablet, and two oxycodone HCl 5.0 mg capsules. The DON also confirmed the oxycodone medication had been distributed from the pharmacy in a capsule form rather than the ordered tablet form. The DON acknowledged it was facility policy that licensed staff remain with residents until medications are ingested 28 Pa. Code 201.18 (b)(1) Management. 28 Pa. Code 211.10 (c) Resident care policies. 28 Pa. Code 211.12 (c)(d)(1)(5) Nursing services.</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 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>(continued on next page)</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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on clinical record review and staff interview, the facility failed to ensure adequate monitoring of behaviors and potential adverse consequences prior to administering psychoactive medications for one of 10 residents reviewed (Resident 2). Findings include: Review of Resident 2's clinical record revealed the resident was admitted to the facility on [DATE], with diagnoses which included anxiety disorder (a group of symptoms, such as stress, anxiety, feeling sad or hopeless, and physical symptoms that can occur after you go through a stressful life event), encephalopathy ( a medical condition characterized by a general dysfunction of the brain that affects cognitive function, consciousness, and behavior), and chronic pain. Review of a quarterly Minimum Data Set Assessment (MDS-a federally mandated standardized assessment process completed at specific intervals to plan resident care) dated April 14, 2025, indicated the resident had a BIMS (brief interview mental screener that aids in detecting cognitive impairment) score of 15(a score of 13-15 indicates a cognitively intact resident). A review of the clinical record revealed multiple physician orders for Lorazepam 0.5mg (psychotropic medication used to treat anxiety) The following orders were documented:April 22, 2025-0.5 mg every 12 hours for anxiety.May 19, 2025-0.5 mg every 12 hours as needed (PRN) for anxiety.August 12, 2025-0.5 mg every 12 hours as needed (PRN)for anxiety.August 14, 2025-0.5 mg every 8 hours as needed (PRN)for anxiety. A review of Resident 2's June 2025 Medication Administration Record (MAR) revealed the resident was administered one dose of as needed (PRN) Lorazepam 0.5mg on June 4, 2025, at 1:35PM. The facility failed to document the specific behaviors the resident was exhibiting for the Lorazepam to be administered, and the Documentation Survey Report for June 2025 noted that the resident was exhibiting no behaviors related to anxiety on that date. A review of Resident 2's August 2025 MAR revealed the resident received Lorazepam on 13 occasions (August 12-27, 2025) without documented evidence of anxiety-related behaviors or symptoms to justify administration. Examples include:August 12, 2025, at 10:50 PMAugust 14, 2025, at 9:26 AM and 9:03 PMAugust 15, 2025, at 9:13 PMAugust 16, 2025, at 9:18 PMAugust 17, 2025, at 6:40 AM and 8:34 PMAugust 18, 2025, at 4:49 AM and 9:02 PMAugust 25, 2025, at 10:06 PMAugust 26, 2025, at 12:21 PM and 11:24 PMAugust 27, 2025, at 9:53 PM An interview with Resident 2 conducted on September 23, 2025, at 12:35 PM revealed the resident reported frequent pain but denied experiencing anxiety symptoms on the above dates. The resident stated she did not request Lorazepam and that staff administered it in addition to her pain medication to help me sleep. Review of Resident 2's MAR confirmed on the following dates the resident was administered the lorazepam in addition to the prescribed controlled substance (drug which has been declared by federal or state law to be illegal for sale or use but may be dispensed under a physician's prescription. The basis for control and regulation is the danger of addiction, abuse, physical and mental harm including death), pain medication Hydrocodone/Acetaminophen 5/325mg (an opioid pain medication) without documented indication. Examples include:June 2, 2025 -Hydrocodone/Acetaminophen at 2:00 PM, 25 minutes after Lorazepam was given.August 14, 2025 -Both medications administered at 9:03 PM.August 17, 2025 -Hydrocodone/Acetaminophen at 8:40 PM, 6 minutes after Lorazepam was given.August 25, 2025 -Hydrocodone/Acetaminophen at 10:05 PM, 1 minute before Lorazepam was given.August 26, 2025 -Hydrocodone/Acetaminophen at 11:26 PM, 2 minutes after Lorazepam was given. The above information documented in the clinical record confirmed Resident 2 was administered a controlled substance pain medication with the as needed (PRN) lorazepam without proper indication for use, as stated in the resident interview.Interview with the Director of Nursing on September 23, 2025, at 1:20 PM confirmed the facility was unable to provide documentation supporting the need for Lorazepam when administered. The DON acknowledged that monitoring of behaviors and clinical indications was not consistently documented. The facility failed to record adequate monitoring for behaviors and the use of psychoactive medication in combination with opioid medication, with no documented evidence supporting the need for administration of the lorazepam. 28 Pa. Code 211.12(c)(d)(1)(3)(5) Nursing services</p>		