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	05/21/2025

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

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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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39929 Based on document review, clinical record review, and staff interviews, it was determined that the facility failed to timely provide the required Skilled Nursing Facility Advance Beneficiary Notice of Non-Coverage (SNF-ABN) to notify one of three residents reviewed (Resident 95) that Medicare Part A coverage for skilled nursing services was ending. Findings Include: A review of Resident 95's clinical record revealed admission to the facility on [DATE], with diagnoses to include fusion of the spine (a surgical procedure that connects two or more vertebrae in the spine to eliminate movement between them, providing stability and pain relief). Review of the resident's Medicare coverage documentation revealed the last day of covered Medicare Part A services was February 24, 2025. Further review revealed the facility did not issue the Skilled Nursing Facility Advance Beneficiary Notice of Non-Coverage (SNF-ABN) form to Resident 95 until February 25, 2025, after Medicare Part A coverage had ended. An interview conducted with the Director of Social Services on May 19, 2025, at 11:00 a.m., confirmed the resident had exhausted Medicare Part A benefits as of February 24, 2025, and acknowledged that the SNF-ABN form had not been provided until the following day. An interview with the Nursing Home Administrator on May 20, 2025, at 1:45 p.m., confirmed the facility's failure to issue the required notice prior to the end of coverage. 28 Pa. Code 201.14 (a) Responsibility of licensee.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0628 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48276 Based on a review of clinical records, facility-initiated transfer notices, and staff interview, it was determined the facility failed to notify the resident and the resident's representative(s) of the transfer in writing and in a language and manner they understand and to provide copies of written notice of facility-initiated hospital transfers of residents to a representative of the Office of the State Ombudsman for one out of 21 residents reviewed (Resident 72). Findings include: A clinical record review revealed Resident 72 was admitted to the facility on [DATE]. Further clinical record review revealed Resident 72 was transferred to a community hospital on December 29, 2024, and was readmitted to the facility on [DATE]. The facility was unable to provide documented evidence the resident and resident representative were notified of the reasons for the transfer in writing or provide documented evidence the facility sent copies of written notices of these transfers to the representative of the Office of the State Long-Term Care Ombudsman. An interview with the nursing home administrator on May 21, 2025, at approximately 10:00 AM confirmed there was no documented evidence that copies of transfer notices for Resident 72 were sent to a representative of the Office of the State Long-Term Care Ombudsman. The nursing home administrator was unable to provide documented evidence that Resident 72 or his representative was notified of the reasons for the transfer on December 29, 2024. 28 Pa. Code 201.14(a) Responsibility of licensee.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48276 Based on a review of clinical records, the Resident Assessment Instrument (RAI), and staff interview, it was determined the facility failed to ensure the Minimum Data Set Assessments accurately reflected the status of one resident out of 21 sampled (Resident 72). Findings include: According to the Resident Assessment Instrument (RAI) User's Manual (an assessment tool utilized to gather definitive information on a resident's strengths and needs, which must be addressed in an individualized care plan, and the RAI also assists staff to evaluate goal achievement and revise care plans accordingly by enabling the facility to track changes in the resident's status) dated October 2024, Section N Medications Subsection N0350A: Insulin, indicate the number of days during the 7-day look-back period that the resident received insulin (a hormone medication used to treat diabetes) injections. A clinical record review revealed Resident 72 was admitted to the facility on [DATE]. A review of a quarterly Minimum Data Set assessment (MDS-a federally mandated standardized assessment process conducted periodically to plan resident care) dated April 11, 2025, Section N Medication Subsection N0250. Insulin revealed that Resident 72 received one injection of insulin during the 7-day look-back period. A review of Resident 72's medication administration record dated April 2025 revealed no documented evidence Resident 72 received an insulin injection during the seven-day look-back period. During an interview on May 21, 2025, at approximately 11:00 AM, the Director of Nursing (DON) confirmed Resident 72 did not receive an insulin injection during the seven-day look-back period, as indicated in the resident MDS assessment dated [DATE]. After inquiries made during the survey, the facility corrected the error and submitted a modification to the April 11, 2025, MDS assessment for Resident 72. 28 Pa. Code 211.12(d)(3) Nursing services.

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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 0689 Level of Harm - 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** 39929 Based on observation, review of clinical records and select facility documentation, and staff and resident interviews, it was determined that the facility failed to ensure that staff implemented a physician-ordered adaptive device (lidded cup) to mitigate the risk of injury from hot liquids for one of 21 sampled residents (Resident 60) resulting in actual harm, a burn injury to the upper thigh area and failed to ensure nurse aides demonstrated the necessary skills and competencies to safely perform mechanical lift transfers for one of 21 residents reviewed (Resident 195). These failures resulted in actual harm to both residents. Findings include: A review of Resident 60's clinical record revealed the resident was admitted to the facility February 1, 2024, with diagnoses to include dementia (the loss of cognitive functioning - thinking, remembering, and reasoning - to such an extent that it interferes with a person's daily life and activities). A quarterly Minimum Data Set assessment (MDS - a federally mandated standardized assessment process conducted at specific intervals to plan resident care) dated May 2, 2025, revealed that the resident was severely cognitively impaired with no BIMS score recorded (Brief Interview for Mental Status, a tool to assess the resident's attention, orientation, and ability to register and recall new information). The assessment noted that during eating, the resident had the ability to use suitable utensils to bring food and /or liquid to the mouth and required set up and clean up assistance Review of physician orders revealed that as of November 5, 2024, and active through May 20, 2025, the resident was to be provided with lidded cups for all liquids. An Occupational Therapy treatment encounter note dated May 13, 2025, identified the resident required set up/clean up assistance for all meals. A nurse's note dated May 19, 2025, at 2:16 PM, indicated that at approximately 11:45 AM that day, Resident 60 spilled hot coffee into her lap. The nurse noted pink, non-blanchable skin and four clear, fluid-filled blisters, each approximately 0.5 cm x 0.5 cm, located on the left anterior thigh. Silvadene was applied per protocol, and the practitioner and resident's family were notified. Resident denied pain and discomfort at that time. A Skin Evaluation completed by Employee 1 the RN Supervisor on May 20, 2025, at 9:15 AM, described six intact, clear fluid-filled blisters across multiple areas of the upper thigh. Left proximal 2 cm x1. 5 cm Left lateral 2 cm x1 cm Left lateral 1cm x 0.5cm (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Left distal 3. 5cm x 1. 5cm Left distal/ lateral 0.5cm x 0.5cm Left medial 3.5 cm x 1cm Silvadene was applied per physician order during the assessment. The resident denied having pain and was resting comfortably in bed with the call bell within reach. A Wound Care Physician evaluation dated May 20, 2025, at 1:53 PM, identified the burn as measuring 8 cm x 25 cm x 0 depth, with no exudate (discharge of moisture) or odor. The wound area was warm to the touch and the skin remained closed. The resident reported no pain. A review of facility's investigative report completed by the Director of Nursing (DON) dated May 19, 2025, at 11:45 AM, indicated the resident had been provided coffee without a lid, in violation of the physician's order, and subsequently spilled the beverage into her lap. A witness statement from Employee 5, Nurse Aide, dated May 19, 2025, revealed during the lunch meal, she placed the coffee in front of the resident without a lid and turned her back toward this resident to prepare another resident's beverage. When she turned back toward the resident she noticed Resident 60 had spilled the coffee into her lap. She reported to the Nursing Home Administrator (NHA) and Director of Nursing (DON) being unaware of the resident's requirement for a lidded cup. Employee 5 was suspended pending investigation and was unavailable to be reached by phone for an interview. On May 21, 2025, at approximately 10:00 AM, with the resident's permission, an observation of the resident's burn was conducted in the presence of the DON. The resident's burn was visible on her upper left thigh. The burn appeared pink, with scattered areas of white. Four blister like clusters remained, with no open areas seen, and no evidence of drainage or odor. Review of Resident 60's Kardex, which is used by staff to determine whether a resident required adaptive equipment for meals, prior to May 19, 2025, revealed the order for a lidded cup was not on the Resident's Kardex. However, the resident did have a physician's order dated originally November 5, 2024, for lidded cups for all fluids. An interview with the NHA on May 21, 2025, at approximately 9:00 AM revealed there was an error in linking the active physician's order for lidded cups to the resident's Kardex. Review of the food and beverage temperature logs maintained by the facility at resident meal service for May 19, 2025. The food/beverage temperatures for May 19, 2025, showed the coffee temperature for lunch tested at 139 degrees Fahrenheit. Interview with the NHA on May 21, 2025, at approximately 10:00 AM confirmed, the resident was not provided the ordered adaptive device (cup with lid). The administrator acknowledged the omission directly contributed to the hot liquid spill and subsequent injury. Following the incident on May 19, 2025, corrective actions were implemented by May 20, 2025, and included: (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Immediate clinical intervention following the incident, including removal of soiled clothing, application of cool compresses, wound treatment, and notification of the practitioner and family. Resident was evaluated by the Occupational Therapist for safety in consuming hot liquids. Occupational Therapist updated orders to include [NAME] Cup (spill proof cup that can be turned upside down without spilling) to further reduce spill risk. Residents with current adaptive equipment orders were prescreened by the Occupational Therapist to verify current orders and interventions are appropriate. Director of Nursing will review each order to verify the order is care planned and visible on the Kardex. Regional Dietician re-educated the facility Dietician on appropriate steps to document orders, so they flow to the care plan and the Kardex. The DON/designee provided in-service to facility staff on hot beverage policy. Staff not present during initial training were reeducated before their next shift. The DON/designee will review new resident orders for adaptive equipment to verify that they are documented correctly including link to Kardex. Implementation of an audit system to review adaptive equipment use, ensure consistency between physician orders, care plans, and Kardex, and present findings to the facility's QAPI committee. A review of the clinical record revealed that Resident 195 was admitted to the facility on [DATE], with diagnoses to include, transient ischemic attach (TIA-a short period of symptoms similar to those of a stroke, caused by a brief blockage of blood flow to the brain), cerebral infarction (occurs when the blood supply to part of the brain is blocked or reduced and prevents brain tissue from getting oxygen and nutrients that results in brain cells beginning to die) without residual deficits (recovered without any effect), age related osteoporosis (a condition in which the bones become thinner, weaker, and more likely to break), and aphasia (a result of a stroke or brain injury that affects a person's ability to communicate). A Significant Change Minimum Data Set assessment (MDS- a federally mandated standardized assessment process conducted at specific intervals to plan a resident's care) dated January 14, 2025, revealed that Resident 195 had severe cognitive impairment with a BIMS score of 3 (Brief Interview for Mental Status - a tool to assess cognitive function - a score of 0 -7 indicates severe cognitive impairment), dependent (helper does all of the effort to complete the activity or the assistance of two or more helpers required to complete the activity) for bed mobility, transfers, toileting, and bathing. The resident was assessed to require a mechanical lift (a mechanical device used to assist with transfers and movement of individuals who require support for mobility beyond the manual support provided by caregivers alone) for all transfers. A review of Resident 195's physician's orders dated December 3, 2024, at 2:02 AM, specified mechanical lift use for all transfers. A review of a facility policy entitled Mechanical Lifting last reviewed February 18, 2025, indicated the facility utilizes floor-based full body sling lifts and overhead full body sling lifts with universal slings (intended as a general transfer sling, designed to be interchangeable between all manufacture's lifts and provides trunk and leg support for patients with limited upper body tone) and refer to the manufacturer's instructions for use of the universal slings. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A review of facility provided investigative documentation completed by Employee 1, Registered Nurse (RN) Supervisor, dated January 30, 2025, revealed that at 8:00 AM, Resident 195 had a witnessed fall by Employee 2, an agency Nurse Aide (NA), and Employee 3, an agency Licensed Practical Nurse (LPN), the resident slid from the sling during a Hoyer lift transfer performed by Employee 2 (agency nurse aide) and Employee 3 (agency LPN), and struck her head on the floor. Employee 1 assessed Resident 195 and noted that the resident was moaning and not answering questions and 911 was called. The Resident's RP (Responsible Party), her son, was made aware and agreeable to send resident to the emergency department and the MD was made aware. A review of a witness statement completed by Employee 2, agency NA, dated January 30, 2025, no time indicated, Employee 2 reported: I was getting her {Resident 195} dressed and washed. I put the sling under her and strapped her up real good. The LPN was in with me when I lifted her up with the Hoyer. She slipped right out, landed on the bed and then on the floor. Wasn't a fall, she slipped onto the floor and hit her head. The LPN went to get the supervisor, and I tried to get her vitals, but she wouldn't let me. She was halfway on the bed when it happened. Employee 3's, agency LPN, witness statement dated January 30, 2025, no time indicated, noted I was called in by the nursing assistant to transfer the resident via Hoyer lift, with safety harness intact. The NA pulled the lift back and the resident slid out of the pad and bounced off the bed to the floor. Resident hit head on the floor. Supervisor was called and safety protocols initiated. A witness statement completed by Employee 4, former Director of Nursing (DON), dated January 30, 2025, documented the reenactment of the event that occurred at approximately 8:20 AM. The DON noted: Employee 2 stated she had retrieved a sling from the laundry, hooked the resident up appropriately, and sought assistance with the transfer. Unable to locate another aide, she was assisted by Employee 3. During the lift, the resident slid out from the bottom of the pad (sling) onto the bed and then onto the floor. When asked whether she crossed the leg straps of the sling, Employee 2 replied, no. Employee 3 described the lift transfer as follows: She was asked to come in and spot the resident transfer. She entered the room and stood by the bed while the lift was being performed. Upon elevation of the resident on the lift, the resident slid out of the bottom onto the bed and then the floor. A review of the emergency department after visit summary dated January 30, 2025, at 11:03 AM, revealed that she was being seen due after a fall off the Hoyer lift. Imaging results completed and CAT scan (computerized axial tomography - uses x-rays to take pictures of your blood vessels, tissues, bones, or organs) of the chest/abdomen/pelvis and CAT scan of her head, brain, and spine and determine that imaging was negative for intercranial bleed and fractures but positive for left posterior scalp hematoma (a condition characterized by the accumulation of blood beneath the scalp and occurs as a result of various factors, including trauma, head injuries, or medical conditions that affect blood clotting) with a planned discharge back to the facility for 11:30 AM. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A review of Resident 195's clinical record revealed a nurses' progress notes dated February 4, 2025, at 10:28 PM, that indicated that the resident was complaining of increased pain to the left thigh area. Resident offered PRN (as needed) Tylenol and declined; resident was agitated and yelling at staff. Refusing all PRN medication but allowed the NA to reposition her in bed. Orders were obtained from the CRNP (Certified Nurse Practitioner) for left hip and femur x-rays and to increase Tramadol (opioid pain medication used to manage moderate to severe pain) to 25 mg po BID (twice per day) to TID (three times per day) and hold for sedation. Further review of the resident's clinical record revealed final x-ray results that indicated a left hip fracture, not present on prior study; clinical correlation and follow up radiographs suggested. CRNP made aware new orders received and noted to send the resident to the hospital emergency room (ER). A review of Resident 195's hospital discharge summary for admission February 5, 2025, through February 10, 2025, revealed the resident was admitted due to a left periprosthetic fracture (are considered fractures associated with an orthopedic implant, whether a replacement or internal fixation device) and multiple closed fractures of ribs (is a common injury that occurs when one of the bones in the rib cage breaks or cracks caused by hard impacts from falls, car accidents or contact sports) of the left side. A review of the manufacturer's instructions for the universal lift sling use during transfers from bed to chair indicated that for maximum security, gently raise the individual's legs, and pull the leg loops forward and under the thigh, cross the loops over the thighs, pull one strap through the other, and bring the lift over to the bed and roll the base as far underneath the bed as possible while positioning the cradle over the individual. When both sides of the sling are attached to their respective sides of the cradle, raise the individual slowly. Place the specific loop or chain the individual requires to ensure the proper fit to prevent from sliding out of the sling. The instructions for the universal sling confirmed that sling leg loops were to be crossed under the thighs and properly secured to prevent the resident from sliding. A review of a facility provided document entitled New Employee Orientation handbook provided by the Nurse Staffing Agency, reviewed and signed by Employee 2, Agency Nurse Aide (NA) on May 11, 2022 (date of hire with the nursing agency), acknowledged that Hoyer lift safety was completed on that date. Additionally, Employee 2 completed the facility's Nursing Agency Orientation on January 17, 2025, which included resident transfer safety. A review of the nursing agency's new hire documentation for Employee 3, Agency LPN, revealed that she was hired by the agency on August 17, 2023, however, no documentation was provided by the facility or staffing agency to demonstrate that Employee 3 had ever received training or competency validation on mechanical lift use. During on-site survey, telephone calls were placed to both Employee 2 and Employee 3, but the employees did not return the calls. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview with the Nursing Home Administrator (NHA) on May 20, 2025, at 10:45 AM, he acknowledged that Employee 2 failed to properly apply the universal sling and failed to cross the leg straps, resulting in the resident sliding from the sling onto the bed and then the floor. He further confirmed the facility was unable to produce documented evidence that Employee 3 had ever received mechanical lift training prior to assisting with the transfer. Further interview with the NHA confirmed that Employee 2 failed to ensure Resident 195's safety when applying the universal sling when performing a Hoyer/mechanical lift transfer that resulted in Resident 195 sliding out of the bottom of the sling onto the bed and then onto the floor hitting her head. Subsequently, Resident 195 sustained a left posterior scalp hematoma, left periprosthetic fracture, and multiple closed fractures of ribs on the left side. The facility failed to ensure that all nursing staff had the necessary clinical competency validation skills when operating mechanical lifts with universal slings for resident transfers to prevent injuries sustained from unsafe transfer practices by staff. Following the incident with Resident 195 on January 30, 2025, the facility provided evidence that corrective actions were completed by January 31, 2025. Resident was assessed for injury (no injury apparent) and was sent to the hospital for an evaluation. The current residents who utilize a Hoyer lift for care were audited to determine the following a-proper sling fitment b-care plan updated The maintenance director/designee re-audited all lifts to ensure proper functioning. Lifts are on a monthly preventative maintenance schedule. The DON/designee will in-service the nursing staff on proper sling use, colors, sizes and location. The ESD audited all slings in the building to ensure they are functional. The NHA/designee will randomly audit nursing staff 2x/week for 4 weeks to ensure the slings/lifts are being used in accordance with manufacturer recommendation and facility policy. 28 Pa Code 201.18(b)(1) Management. 28 Pa Code 211.10 (d) Resident care policies. 28 Pa Code 211.12 (d)(3)(5) Nursing services.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39929 Based on a review of clinical records and interviews with staff, it was determined the facility failed to ensure residents maintain acceptable parameters of nutritional status, such as usual body weight, unless the resident's clinical condition demonstrates that is not possible, for one out of 21 residents sampled (Resident 51). Findings include: A facility policy titled Weighing of Residents, last reviewed by the facility on February 18, 2025, revealed it is the facility's policy to monitor residents' weight to detect significant weight loss or gain in order to ensure that the resident maintains acceptable parameters of nutritional status. The policy indicates if the resident exhibits a weight change of 5 lbs from the previous weight, the resident shall be re-weighed within 24 hours and the re-weighing shall be recorded. If the re-weight is validated as a 5% change, the registered dietician completes an assessment to investigate the cause of the weight change. The policy states the charge nurse will notify the registered dietician, doctor, family, and registered nurse assessment coordinator of significant weight changes. A clinical record review revealed Resident 51 was admitted to the facility on [DATE], with diagnoses that include dementia (a condition characterized by the loss of cognitive functioning such as thinking, remembering, and reasoning, to such an extent that it interferes with a person's daily life and activities). A review of an annual Minimum Data Set assessment (MDS-a federally mandated standardized assessment process conducted periodically to plan resident care) dated April 14, 2025, revealed that Resident 51 was severely cognitively impaired with a BIMS score of 03 (Brief Interview for Mental Status- a tool within the Cognitive Section of the MDS that is used to assess the resident's attention, orientation, and ability to register and recall new information; a score of 00-07 indicates cognition is severely impaired). A care plan focus indicating Resident 51 has an enteral feeding tube (a method of delivering nutrition directly into the gastrointestinal (GI) tract through a feeding tube) to meet nutrition and hydration needs related to dysphagia (a condition that creates blockages or causes your throat or esophagus to be too narrow can make it hard to swallow) was initiated on May 17, 2022. Interventions developed to assist Resident 51 with her goal for maintaining weight over the next 90 days included treatment as ordered for gastronomy tube (a thin, flexible tube inserted into the stomach through a small incision in the abdominal wall) and weighing the resident as ordered. An additional care plan focus indicated Resident 51 was at nutritional risk related to an inability to meet nutritional needs with oral intake and required a gastronomy tube initiated on May 25, 2022. Interventions developed to assist Resident 51 with her goal of consuming oral intake as able and continuing to tolerate enteral feedings to meet estimated nutritional needs include weighing per orders and alerting the dietitian and physician to any significant weight loss or gain and monitoring for changes in nutritional status (unplanned weight loss or gain) and reporting to the physician as indicated. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further clinical record review revealed Resident 51 weighed 144.2 lbs on April 11, 2025, and weighed 134.4 lbs on May 5, 2025, a 9.8 lb weight loss (-6.8 %) in 24 days. Resident 51 was reweighed 4 days later on May 9, 2025, and weighed 135.2 lbs, a 9.0 lb weight loss (-6.24%) in 28 days. An unplanned weight loss greater than 5.0% in 30 days is considered a significant weight loss. A clinical record review revealed there was no documented evidence Resident 51 was reweighed within 24 hours as indicated in the facility policy following the identification of significant weight loss on May 5, 2025. There was no documented evidence Resident 51 was reweighed within 24 hours as indicated in the facility policy following the identification of significant weight loss on May 9, 2025. A clinical record review of Resident 1's assessments tab on the electronic health record revealed no documented evidence that a nutritional assessment was completed following the identification of significant weight loss on May 5, 2025, or May 9, 2025. A nutrition progress note dated May 15, 2025, at 3:01 PM revealed Resident 51's significant weight loss of -6. 6% over the last 30 days. The note included a recommendation for weekly weight monitoring. Further clinical record review revealed no documented evidence the physician or resident representatives were notified regarding the identification of significant weight loss. During an interview on May 20, 2025, the Registered Dietician (RD), confirmed there was no documented evidence that Resident 51's significant weight loss was reviewed until 10 days after it was identified. The RD confirmed there was no documented evidence the physician or Resident 51's representative was notified following the identification of a significant weight loss on May 5, 2025, or May 9, 2025. 28 Pa Code 211.5 (f)(ii)(iii)(x) Medical records. 28 Pa. Code 211.10(c) Resident care policies. 28 Pa Code 211.12 (d)(1)(3)(5) Nursing services.

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	05/21/2025

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 43944 Based on observation and staff interview, it was determined that the facility failed to maintain acceptable practices for the storage and service of food to prevent the potential for contamination and microbial growth in food, which increased the risk of food-borne illness in the dietary department. Findings include: Food safety and inspection standards for safe food handling indicate that everything that comes in contact with food must be kept clean and food that is mishandled can lead to foodborne illness. Safe steps in food handling, cooking, and storage are essential in preventing foodborne illness. You cannot always see, smell, or taste harmful bacteria that may cause illness according to the USDA (The United States Department of Agriculture, also known as the Agriculture Department, is the U.S. federal executive department responsible for developing and executing federal laws related to food). Review of a facility policies titled Refrigerator and Frozen Food Storage last reviewed by the facility on February 18, 2025, indicated that all TCS (time, temperature, control foods) and ready to eat foods prepared on site and held for longer than 24-hours, must be properly labeled and dated with the date by which it should be consumed or discarded (use by date). The initial tour of the dietary department was conducted with the facility's weekend dietary supervisor on May 18, 2025, at 8:45 AM, revealed the following unsanitary practices with the potential to introduce contaminants into food and increase the potential for food-borne illness, were identified: Observations of inside the reach-in tray line refrigerators revealed that the following foods failed to include use by date or thaw date as follows, two opened half gallons of chocolate milk, one prepared plated tossed salad with chicken, one opened gallon of milk, and one opened can 8-ounce cola. Further observations of the reach-in tray line refrigerators revealed that the following nutritional supplements were thawed but failed to include a thaw date or discard date as follows, four thawed 6-ounce nutritional juice drinks (high calorie/high protein supplement) and twelve thawed Magic Cup (high calorie/high protein supplement) supplements. The manufacture's safe food handling instructions indicate that once defrosted, supplements should be used within 14-days. However, the actual discard date was not able to be determined due to items lacking a noted thaw date or discard date on each item. The dietary supervisor confirmed the above observations and indicated that all food items that were opened and/or thawed inside the refrigerator should have a use by date or thaw date listed on the items to prevent the potential for food contamination and foodborne illness. 28 Pa. Code 201.18 (e) (2.1) Management 28 Pa. Code 211.6 (f) Dietary Services