STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395728	A. Building B. Wing	05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lecom at Snyder Memorial	156 Snyder Memorial Rd Marienville, PA 16239

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31185 Based on review of the Resident Assessment Instrument (RAI-manual that guides facilities with completing resident Minimum Data Set [MDS-periodic assessment of resident care needs] assessments), clinical records, facility documentation, and staff interviews, it was determined that the facility failed to complete the MDS to accurately reflect the resident's status at the time of the assessment for seven of 21 residents reviewed (R8, R9, R13, R15, R41, R55, and R76). Findings include: Review of the October 2024 RAI Manual revealed that restraints (a device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily, which restricts freedom of movement or normal access to one's body) used in the seven-day assessment look-back period were to be documented in Section P (Restraints and Alarms) of the MDS, coding 0 for not used, 1 for used less than daily, and 2 for used daily. Review of Resident R8's clinical record revealed an admitted [DATE], with diagnoses that included epilepsy, bipolar disorder, and anxiety (a condition that causes a person to be nervous, uneasy, or worried about something or someone). A Quarterly MDS dated [DATE], under Section P0100A, revealed that Resident R8's bed rails were coded as a restraint used daily. A physician's order dated 3/27/25, indicated Resident R8 was to have bilateral one-half side rails for bed mobility every shift. An incident report dated 2/28/25, revealed Resident R8 sustained a fall and was transferred to the hospital and returned with staples to the head. A Quarterly MDS dated [DATE], under section J1900, revealed Resident R8 had zero falls with major injury. Observations between 5/5/25, and 5/8/25, revealed Resident R8 had two quarter-sized rails on the bed. Review of Resident R9's clinical record revealed an admitted [DATE], with diagnoses that included heart disease, mood disorder, and anxiety. A Quarterly MDS dated [DATE], under Section P0100A, revealed that Resident R9's bed rails were coded as a restraint used daily. A physician's order dated 3/27/25, indicated Resident R9 was to have left, one-half side rails for bed mobility every shift. Observations between 5/5/25, and 5/8/25, revealed Resident R9 had one quarter-sized rail on the bed. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident R13's clinical record revealed an admitted [DATE], with diagnoses that included pulmonary embolism (blood clot in the lung), paraplegia (paralysis of both legs and lower part of body), and pressure ulcers (wounds caused by prolonged pressure). A Quarterly MDS dated [DATE], under Section P0100A, revealed that Resident R13's bed rails were coded as a restraint used daily. A physician's order dated 3/27/25, indicated Resident R13 was to have bilateral one-half side rails for bed mobility every shift. Observations between 5/5/25, and 5/8/25, revealed Resident R13 had two quarter-sized rails on the bed. Review of Resident R41s clinical record revealed an admitted [DATE], with diagnoses that included atrial fibrillation (irregular heartbeat), heart failure, and alcohol abuse with alcohol induced psychotic disorder. A Quarterly MDS dated [DATE], under Section P0100A, indicated that Resident R41's bed rails were coded as a restraint used daily. A physician's order dated 3/27/25, indicated Resident R41 was to have one-half side rails two times a day for transfer. Observations between 5/5/25, through 5/8/25, revealed Resident R41 had two quarter-sized rails on the bed. Review of Resident R15's clinical record revealed an admitted [DATE], with diagnoses that included hemiplegia (a condition where a person is paralyzed and unable to move one side of their body), anxiety, and diabetes (a health condition that caused by the body's inability to produce enough insulin). A Quarterly MDS dated [DATE], under Section P0100A, revealed that Resident R15's bed rails were coded as a restraint used daily. A physician's order dated 3/27/25, indicated Resident R15 was to have bilateral one-half side rails for bed mobility every shift. Observations between 5/5/25, through 5/8/25, revealed Resident R15 had two quarter-sized rails on the bed. Review of Resident R55's clinical record revealed an admitted [DATE], with diagnoses that included pyschotic disorder, mood disorder, and profound intellectual disabillities. A Quarterly MDS dated [DATE], under Section P0100B, revealed that Resident R55 was coded as trunk restraint not used. A physician's order dated 4/16/25, indicated that Resident R55 had an order for PSD (pelvic safety device) in SBC (straight back chair) for periods of low stimulation and calm during mealtimes, check and release every two hours and as needed for 15 minutes. Observations between 5/5/25, and 5/8/25, revealed Resident R55 had a PSD on while up in chair. Review of Resident R76's clinical record revealed an admitted [DATE], with diagnoses that included bipolar disorder, blindness in one eye, high blood pressure and anxiety. A Quarterly MDS dated [DATE], under Section P0100A, revealed that Resident R76's bed rails were coded as a restraint used daily. A physician's order dated 3/27/25, indicated Resident R76 was to have left one-half side rails for bed mobility every shift. Observations between 5/5/25, and 5/8/25, revealed Resident R76 had one quarter-sized rail on the bed. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/7/25, at 12:45 p.m. the Director of Nursing confirmed that Residents R8, R9, R13, R15, R41, R55, and R76 MDS's Section P0100A as listed above were coded incorrectly and the quarter-sized rails were not used as restraints. During an interview on 5/7/25, at 1:45 p.m. the Nursing Home Administrator confirmed that Resident R8's MDS Section J1900 was coded incorrectly regarding falls with major injury. 28 Pa. Code 211.5(f)(i)(ii)(ix) Medical records

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48496 Based on review of facility policy, clinical records, and staff interview, it was determined that the facility failed to review and revise comprehensive care plans to reflect the current care and services for one of 21 residents reviewed (Resident R34). Findings include: Review of facility policy entitled Care Plans dated 4/1/25, indicated The care plan will be reviewed, evaluated and updated with any significant change ., and Care plans will outline resident's care needs based on . physician orders . Review of Resident R34's clinical record revealed an admitted [DATE], with diagnoses that included chronic obstructive pulmonary disease (when your lungs do not have adequate air flow), chronic respiratory failure (a condition where your lungs don't exchange air properly), and sleep apnea (a condition when a person repeatedly stops and starts breathing when they are sleeping). Review of Resident R34's physician orders revealed an order for O2 (oxygen) via NC (nasal cannula-oxygen delivery) 2-3LPM (liters per minute) continuous, goal sats (oxygen saturation percent) 88-92%, dated 10/14/23. Review of Resident R34's care plans revealed a plan of care for recent history of tracheostomy with interventions for oxygen via nasal cannula at 2L PRN (as needed), and a plan of care for ADL self-care deficit with an intervention of oxygen at 2L via nasal cannula continuously. During an interview on 5/7/25, at 1:40 p.m. the Director of Nursing (DON) confirmed the care plans for Resident R34's oxygen were not reviewed/revised to reflect current resident care and services. He/she also confirmed that care plans should be reviewed and revised as necessary. 28 Pa. Code 211.5(f)(i) Medical records 28 Pa. Code 211.10(c)(d) Resident care policies 28 Pa. Code 211.12(d)(1)(5) Nursing services

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48496 Based on review of facility policies and clinical records, observations, and staff interview, it was determined that the facility failed to provide oxygen according to physician's orders for one of 25 residents reviewed (Resident R34). Findings include: Review of facility policy entitled Oxygen Administration dated 4/1/25, indicated Check physician's order for liter flow . Review of facility policy entitled Documentation, Clinical dated 4/1/25, indicated Documentation shall be done by nursing staff according to the needs of the resident and the care provided. Review of Resident R34's clinical record revealed an admitted [DATE], with diagnoses that included chronic obstructive pulmonary disease (when your lungs do not have adequate air flow), chronic respiratory failure (a condition where your lungs don't exchange air properly), and sleep apnea (a condition when a person repeatedly stops and starts breathing when they are sleeping). Review of Resident R34's physician's orders revealed an order for O2 (oxygen) via NC (nasal cannula-oxygen tubing that has prongs that go into the nostrils and loops around the ears to secure in place to ensure adequate oxygen delivery) 2-3LPM (liters per minute) continuous, goal sats (oxygen saturation percent) 88-92%, dated 10/14/23. Review of Resident R34's oxygen saturation documentation revealed it lacked evidence that his/her oxygen saturation was obtained routinely to know if he/she was within his/her oxygen goal sats per physician orders. During an interview on 5/7/25, at 1:40 p.m. the Director of Nursing (DON) confirmed that Resident R34's clinical record lacked evidence of his/her oxygen saturation percentages to ensure that he/she was within his/her oxygen goal sats. He/she also confirmed that Resident R34's oxygen saturation levels should be monitored to ensure he/she is within his/her oxygen goal sats per physician orders. 28 Pa. Code 211.10(c) Resident care policies 28 Pa. Code 211.12(d)(1)(5) Nursing services

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly 48496 Based on review of facility records and staff interview, it was determined that the facility failed to ensure required attendance of the Director of Nursing and Infection Preventionist to Quality Assurance and Performance Improvement (QAPI) Committee meetings for two of four quarterly QAPI Committee meetings. Findings include: Review of facility policy entitled Leadership and Communication dated 4/1/25, indicated the facility will have a QAPI steering committee which included the following members Administrator, Director of Nursing, Infection Control, Medical Director . and Committee Members - Per CMS regulations . Review of the QAPI Committee Attendance Records for the October 2024 meeting revealed no evidence on the attendance sign-in for the required QAPI meeting that the Director of Nursing was in attendance. Review of the QAPI Committee Attendance Records for the February 2025 meeting revealed no evidence on the attendance sign-in sheets for the required QAPI meeting that the Infection Preventionist was in attendance. During an interview on 5/8/25, at 12:15 p.m. the Nursing Home Administrator (NHA) confirmed the facility lacked evidence that the Director of Nursing and the Infection Preventionist attended the Quarterly QAPI Committee meetings as required. He/she also confirmed that the Director of Nursing and the Infection Preventionist should be in attendance for the QAPI meetings as required. 28 Pa. Code 201.18(e)(1)(3) Management

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47356 Based on review of facility policies and clinical records, observations, staff interviews, and resident interview, it was determined that the facility failed to maintain proper infection prevention and control isolation by failing to remove isolation precautions for non-transmittable diseases which were confirmed by laboratory testing for three of five residents reviewed on droplet precautions (a type of transmission based precautions used to prevent the spread of respiratory infections) (Residents R56, R77, and R33). Findings include: Review of the facility policy entitled Policy on Isolation and Infection Precautions dated 4/1/25, revealed when it is determined that a resident needs isolation or special infection precautions to prevent the spread of infection, the appropriate isolation and/or precautions are utilized. Review of the facility policy entitled Infection Prevention & Control Program dated 4/1/25, revealed prevention of spread of infections is accomplished by the use of Standard and Transmission based precautions and other barriers, appropriate treatment and follow-up .Transmission based precautions chosen based on circumstances and are least restrictive as possible. Review of Resident R56's clinical record revealed an admitted [DATE], with diagnoses that included neuralgic amyotrophy (nerve damage and muscle wasting that causes severe pain), anxiety, depression, and other seasonal allergic rhinitis. Review of Resident R56's clinical record revealed progress notes dated 4/21/25, indicating he/she was placed on droplet precautions and that rapid COVID testing was negative. Progress notes on 5/1/25, revealed he/she was tested for flu and COVID in the emergency room , which were both negative. Clinical record vitals indicated that Resident R56 remained afebrile (free of fever). Resident R56's Brief Interview for Mental Status (BIMs-15-point cognitive screening measure that evaluates memory and orientation and includes free and cued recall items) was 15 (cognitively intact). Interview conducted with Registered Nurse Employee E2 on 5/5/25, at approximately 2:00 p.m. revealed Resident R56 was on droplet precautions and he/she was unaware of any positive testing that would require droplet isolation. Interview conducted with Resident R56 on 5/6/25, at approximately 9:30 a.m. revealed he/she is very dissatisfied with the isolation precautions because all testing has been negative. He/she prefers to be out and about to socialize, but is uncomfortable wearing a mask, therefore he/she stays in his/her room. Review of Resident R77's clinical record revealed an admitted [DATE], with diagnoses that included dementia (thinking and social symptoms that interfere with daily living), weakness, pulmonary embolism (blood clot in lung), and dysphagia (difficulty swallowing). (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident R77's clinical record revealed progress notes dated 4/29/25, indicating he/she was placed on droplet precautions and that rapid COVID testing was negative. Clinical record vitals indicated that Resident R77 remained afebrile. Review of Resident R33's clinical record revealed an admitted [DATE], with diagnoses that included dementia, anxiety, dysphagia, and hypertension (high blood pressure). Review of Resident R33's clinical record revealed progress notes dated 4/29/25, indicating he/she was placed on droplet precautions and that rapid COVID testing was negative. Clinical record vitals indicated that Resident R33 remained afebrile. Interview conducted with Licensed Practical Nurse (LPN) Employee E1 on 5/6/25, at 9:06 a.m. revealed Residents R56, R77, and R33 are generally not in their rooms. He/she indicated Resident R56 is alert and oriented and enjoys socializing, which is beneficial due to Resident R56 becoming more depressed related to some new diagnoses. LPN Employee E1 indicated Residents R77 and R33 are always brought out of their rooms and into the living room for stimulation and socialization and have not been able to do so related to the isolation. During an interview on 5/6/25, at approximately 10:45 a.m. the Infection Control Infection Preventionist confirmed that Residents R56, R77, and R33's testing for transmittable diseases were negative and that isolation should have been discontinued at that time. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18(b)(1) Management 28 Pa. Code 201.18(e)(1) Management 28 Pa. Code 211.12(d)(1)(5) Nursing services