

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  396049	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/04/2024
NAME OF PROVIDER OR SUPPLIER  Jameson Nursing and Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE  3349 Wilmington Road New Castle, PA 16105	

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 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 41309</p> <p>Based on review of facility policies, facility documentation, and clinical record, and resident and staff interviews, it was determined that the facility failed to ensure residents were free from neglect for one of 14 residents reviewed (Resident R1).</p> <p>Findings include:</p> <p>Review of facility policy entitled Abuse and neglect clinical protocol Revised March 2018, revealed Neglect: The failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress.</p> <p>Review of facility policy entitled Falls-Clinical Protocol Revised March 2018, revealed Falls should be categorized by: those that occur while trying to rise from a sitting or lying to a standing position, those that occur while upright and attempting to ambulate, and other circumstances such as sliding out of a chair or rolling from a low bed to the floor.</p> <p>Review of Resident R1's clinical record revealed an admitted [DATE], with diagnoses that included fracture of the head and neck of the left femur, atrial fibrillation (irregular heart beat), and heart failure.</p> <p>Review of Resident R1's Quarterly Minimum Data Set (MDS - an assessment tool used to facilitate the management of care) assessment dated [DATE], revealed under section G transfers, that Resident R1 required extensive assistance with transfers.</p> <p>Review of Resident R1's Care Plan revealed that the resident was an assist of two with transfers, resident was non-weight bearing.</p> <p>Review of information submitted by the facility dated 8/21/2024, revealed Resident R1 was incorrectly transferred by one employee after receiving a shower in the shower room and was lowered to the floor resulting in a fall to him/her.</p> <p>(continued on next page)</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 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the facility's investigation revealed an employee statement by Nurse Aide (NA) Employee E1 that identified that NA Employee E1 confirmed on 8/21/24, at about 8:10 p.m. he/she transferred Resident R1 to the shower with Employee E2 and Resident R1 was then assisted onto the shower chair. The shower was completed. Resident R1 apparently kept leaning forward during the shower. Employee E1 then stated, helped her stand and tried to pull lounge chair behind her. It would not move very well, so I yelled four times I need help in here. No one came so I had to lower her to the floor and came out to get help.</p> <p>Review of NA Employee E2's statement revealed, This aid helped get Resident on shower chair and helped get her into shower. This aid told the aid to let any of us know to help get her back in to the chair after the shower. This aid proceeded to leave shower room to change and get into bed a resident. This aid proceeded to stay at nurse's station to wait for aid to say they were done. Aid finally opened door for help and this aid went to help when this aid opened door, this aid saw resident sitting on the floor. Four people went in to help get her into her chair. [He/she]stated [he/she] yelled for help four times, but we were all at the nurse's station and did not hear anything.</p> <p>Review of Registered Nurse (RN) Supervisor Employee E3's statement revealed that the resident was being showered in shower room; Employee E1 did not ask for assistance and did not hit the call bell in shower room for assistance; He/she stated he/she lowered the resident to the floor; and the resident was found on tile floor and was assessed.</p> <p>Review of documentation submitted by the facility dated 8/23/24, revealed that the facility initiated an investigation, regarding resident neglect. NA Employee E1 was suspended from work during the investigation process. NA Employee E1 was terminated from work on 8/27/24, due to failing to follow the resident plan of care resulting in resident suffering a fall in the shower room. Employee Education was conducted.</p> <p>During an interview on 10/02/24, at 12:30 p.m. the Nursing Home Administrator (NHA) confirmed that NA Employee E1 transferred Resident R1 by physically lifting him/her and not obtaining assistance of two people resulting in a fall in the shower with no harm or injury to Resident R1. He/she also confirmed that the resident should have been transferred as care planned with the assist of two people to a wheelchair.</p> <p>28 Pa. Code 201.14(a) Responsibility of licensee</p> <p>28 Pa. Code 201.18(b)(1) Management</p> <p>28 Pa. Code 201.18(e)(1) Management</p> <p>28 Pa. Code 211.12(c) Nursing services</p> <p>28 Pa. Code 211.12(d)(1)(3)(5) Nursing services</p>		