| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 396063 | A. Building<br>B. Wing | 01/28/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Seton Manor Nursing and Rehabilitation Center | 1000 Seton Drive<br>Orwigsburg, PA 17961 |

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 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 17709<br><br>Based on clinical record review, observation, and staff interview, it was determined that the facility failed to ensure that the environment was free of accident hazards on one of three nursing units, (Cloister nursing unit) and for one of three residents who were confused and ambulatory on the nursing unit. (Resident 1)<br><br>Findings include:<br><br>Clinical record review revealed that Resident 1 resided on the Cloister nursing unit which is a locked dementia unit. Resident 1 had diagnoses that included dementia with anxiety and behavioral disturbance, mental disorder and depression. The Minimum Data Set assessment dated [DATE], indicated that the resident had cognitive impairment and exhibited physical, verbal and other types of behaviors that included hitting and/or grabbing at least one to three times a week. A review of the care plan revealed that the resident was at risk of attempting to eat or drink non-edible or non-consumable items.<br><br>Review of nursing documentation revealed that Resident 1 was independently ambulatory and frequently would ambulate in and out of other resident rooms. On January 23, 2025, at 2:47 p.m., a nurse noted that Resident 1 had ingested Derma/Vera, a skin and hair cleanser. Review of the facility investigation revealed that the resident had been found in the activity room and was observed with the Derm/Vera soap bottle up to her mouth with the lid off of the bottle.<br><br>Observations on the Cloister nursing unit on January 28, 2025, from 10:45 a.m., through 11:15 a.m., revealed the following:<br><br>In the bathroom of resident room [ROOM NUMBER], there was a bottle of Derma/Vera skin and hair cleanser on top of the bathroom sink on the counter and the door to the bathroom was open. Additionally in this room in the closet there was a basin on the floor with personal hygiene items. The items in the basin included a bottle of skin and hair cleanser, two bottles of moisturizing lotion, two tubes of per-guard, skin protectant,ointment, a bottle of medicated protective powder, one bottle of Derma-Septin ointment, and a small bottle of a bath and body fragrance spray. The closet door was open.<br><br>(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 |
|---|---|---|

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | In the bathroom of resident room [ROOM NUMBER], there was a can of hair spray and a bottle of foaming hand cleanser on top of the bathroom sink on the counter. The door to the bathroom was open. In the bathroom of room [ROOM NUMBER] there were three large bottles of moisturizing lotion and a tube of toothpaste. The door to this bathroom was open.<br><br>During the observations between 10:45 a.m., and 11:15 a.m., Resident 1 was ambulating near the resident rooms that had the doors open.<br><br>In an interview on January 28, 2025, at 12:10 p.m., the Director of Nursing and the Assistant Director of Nursing stated that all personal hygiene items were to be kept out of reach of confused residents.<br><br>28 Pa. Code 211.12(d)(1)(5) Nursing services. |