STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	396063	A. Building B. Wing	04/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Seton Manor Nursing and Rehabilitation Center	1000 Seton Drive 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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36935 Based on observation, clinical record review, and staff interview, it was determined that the facility failed to ensure that a dignified environment, care, and services were provided to promote quality of life on three of three nursing units and in the dining room for four residents in one of three dining rooms. (Resident 1, 9, 64, 95) Findings include: Observation on the Cloister nursing unit on April 23 and 24, 2024, revealed a white board in the dining room displaying the date of April 20, 2024, and activities listed for that day. Observation on the Sub-Acute nursing unit on April 23 and 24, 2024, revealed the white boards in the residents' rooms displaying the date of April 20, 2024, and the staff listed for that day. Clinical record review revealed that Resident 1 had diagnoses that included dementia and depression. Review of Resident 1's current care plan revealed that the resident was on a restorative nursing program for dining and needed supervision and occasional assistance with meals. Observation on April 23, 2024, from 12:25 p.m. through 12:55 p.m., revealed Resident 1 in the dining room eating chicken parmesan with spaghetti noodles and Italian vegetables with his fingers. At no time did staff redirect or offer assistance to Resident 1. Clinical record review revealed that Resident 9 had diagnoses that included dementia and Alzheimer's disease. Review of the Minimum Data Set (MDS) assessment, dated February 9, 2024, revealed that the resident had cognitive impairment, and required supervision or touch assistance with eating. Review of the current care plan revealed that Resident 9 was on a restorative nursing program for dining and needed supervision and staff cueing. On April 23, 2024, from 12:25 p.m. through 12:55 p.m., Resident 9 was observed eating spaghetti noodles, chicken, and Italian vegetables with her fingers. At no time did staff redirect or offer assistance to Resident 9. (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Clinical record review revealed that Resident 64 had diagnoses that included dementia and depression. Review the resident's current care plan revealed that Resident 64 was on a restorative nursing program for dining and staff was to provide assistance as needed. Observation on April 23, 2024, from 12:25 p.m. through 12:55 p.m., revealed Resident 64 eating chicken parmesan with spaghetti noodles and Italian vegetables with her fingers. Observation on April 24, 2024, from 12:25 p.m. through 12:45 p.m., revealed Resident 64 eating chicken and vegetables with her fingers. At no time did staff redirect or offer assistance to Resident 64. Clinical record review revealed that Resident 95 had diagnoses that included cerebral infarction (stroke), Alzheimer's disease, and depression. The MDS assessment dated [DATE], indicated that the resident had cognitive impairment and required staff assistance for bathing. According to the task flowsheet, the resident was to receive a shower twice per week on Monday and Thursday. There was no documented evidence that Resident 95 was showered on February 8 or 22, 2024, March 25, 2024, April 15, 2024, or April 23, 2024. In an interview on April 26, 2024, at 11:41 a.m., the Director of Nursing confirmed there was no documented evidence that showers were given as scheduled. 28 Pa. Code 201.29 (a) Resident rights. 28 Pa. Code 211.12(d)(5) Nursing services.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. 36935 Based on clinical record review, observation, review of facility documentation, and staff and resident interview, it was determined that the facility failed to accommodate resident needs in a timely manner by responding to the call bell system for one of three nursing units. (Long Term Care unit) Findings include: Clinical record review revealed that Resident 76 had diagnoses that included paraplegia (paralysis), dysphagia (difficulty swallowing), anxiety, and depression. According to the Minimum Data Set assessment, dated May 16, 2024, the resident had no cognitive impairment. Review of the care plan revealed that the resident was at risk for falls and that staff was to keep the call bell within reach and encourage it's use because the resident needed prompt response to all requests for assistance. On April 23, 2024, at 10:30 a.m. , the resident was observed in bed with the call bell activated. In an interview at 10:51 a.m., Resident 76 stated she had been waiting to get up for the day and no one answered her call bell. Resident 76 also stated at that time, that she often waits extended periods of time for someone to answer her call bell. During a group interview conducted on April 24, 2024, at 10:30 a.m., Residents 16, 30, 53, 54, 84, and 85 reported that they often wait a long time when they or others activate their call bell for assistance. Review of call bell audits revealed that for the week of April 1, 2024, 10 call bell audits were conducted. Eight of the call bell response times were between 31 and 54 minutes. Review of the call bell audits completed for the week of April 15, 2024, revealed that 10 of 10 call bell audits had response times between 35 and 64 minutes. In an interview on April 26, 2024, at 10:50 a.m., the Nursing Home Administrator and Director of Nursing stated that call bells were expected to be answered in a timely manner. 28 Pa. Code 211.12(d)(5) Nursing services.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 45244 Based on clinical record review and staff interview, it was determined that the facility failed to notify the resident representative of a change in condition for one of 27 sampled residents. (Resident 34) Findings include: Clinical record review revealed that Resident 34 had diagnoses that included diabetes, soft tissue disorders, and adjustment disorder with mixed anxiety and depressed mood. Review of the Minimum Data Set assessment, dated February 5, 2024, revealed the resident had cognitive impairment. Review of a nurse's note dated April 20, 2024, revealed that Resident 34's lower left leg was observed to be red and warm with new orders from the physician for doxycycline (antibiotic) and a venous doppler (ultrasound to evaluate blood flow). There was no documented evidence that the resident's representative was notified of the change in condition. In an interview on April 26, 2024, at 10:45 a.m., the Administrator confirmed that the resident's representative was not notified of the change in condition. 28 Pa. Code 211.12(d)(1)(5) Nursing services.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 45840 Based on clinical record review and staff interview, it was determined that the facility failed to develop a comprehensive care plan that addressed individual resident needs as identified in the comprehensive assessment for one of 27 sampled residents. (Resident 45) Findings include: Clinical record review revealed that Resident 45 had diagnoses that included anxiety, bipolar disorder, and Parkinson's disease. The Minimum Data Set (MDS) assessment completed on August 1, 2023, indicated the resident had moderately severe depression. According to the Care Area Assessment summary from that assessment, the facility identified that mood state was a problem area for the resident and should have been included on the comprehensive care plan. Review of the care plan revealed that the facility did not develop interventions to address this care area. In an interview on April 26, 2024, at 11:33 a.m., the Director of Nursing confirmed that Resident 45's care plan did not include the area of potential concern identified in the comprehensive assessment. 28 Pa. Code 211.12(d)(5) Nursing services.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36935 Based on facility policy review, clinical record review, and staff interview, it was determined that the facility failed to assess and document the status of wounds for one of four sampled residents with wounds. (Resident 28) Findings include: Review of the facility policy entitled, Skin Management Guidelines, last reviewed December 27, 2023, revealed that staff was to evaluate and document wound status weekly. Clinical record review revealed that Resident 28 was admitted to the facility on [DATE], with diagnoses that included a sacral pressure sore and congestive heart failure. Review of the Minimum Data Set assessment dated [DATE], revealed that Resident 28 had a Stage 3 pressure sore since admission to the facility. Review of the nursing notes revealed that the resident was being treated for a pressure sore to their sacrum. Review of Resident 28's skin and wound evaluation records revealed that there was no documented evidence that staff assessed the resident's wounds the weeks of January 28, 2024, February 11, 2024, February 25, 2024, and March 17, 2024. In an interview on April 26, 2024, at 11:54 a.m., the Director of Nursing confirmed that there was no documented evidence that Resident 28's wounds were assessed weekly per facility policy. 28 Pa Code 211.12(d)(1)(5) Nursing services.

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F 0689 Level of Harm - Minimal harm or potential for 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** 36935 Based on clinical record review and observation, it was determined that the facility failed to provide adequate supervision to prevent accident/hazards on one of three nursing units. (Cloister unit) Findings include: Clinical record review revealed that Resident 9 had diagnoses that included dementia and Alzheimer's disease. Review of the Minimum Data Set (MDS) assessment dated [DATE], revealed that the resident was cognitively impaired and needed staff supervision with eating. Review of the resident's current care plan revealed that Resident 9 was on a restorative nursing program for dining and staff was to supervise and provide cueing. Observation on April 23, 2024, from 12:25 p.m. through 12:55 p.m., revealed Resident 9 eating in the dining room on the nursing unit. During this time Resident 9 was observed mixing straw wrappers, creamers, and salt and pepper packets in with her food. Resident 9 took her menu, straw wrapper, and spaghetti noodles and put them in her cup of coffee and proceeded to drink from the cup. At no time did staff redirect or assist the resident. At 1:05 p.m., Resident 9 was observed taking packets of condiments off of the counter in the dining room. From 1:07 p.m. through 1:16 p.m., Resident 9 was reaching in the sink touching and handling dirty dishes. Observation on April 24, 2024, at 12:32 p.m., revealed Resident 9 in the dining room eating lunch. Resident 9 was feeding herself with her spoon in her hand raised to her mouth. The spoon contained pieces of food and an intact packet of pepper. Staff did not intervene until made aware by the surveyor at that time. Clinical record review revealed that Resident 64 had diagnoses that included dementia and depression. Review of the resident's current care plan revealed that Resident 64 was on a restorative nursing program for dining and staff was to provide assistance as needed. On April 24, 2024, at 12:30 p.m., Residents 64 and 69 were eating lunch at a table in the dining room. Resident 64 was observed tearing a sugar packet in half and putting one half in her mouth including half the wrapper. At 12:40 p.m., Resident 64 took Resident 69's cake from her tray, put it in her lap, and ate it. Clinical record review revealed that Resident 117 had diagnoses that included dementia and anxiety. Review of the MDS assessment dated [DATE], revealed that the resident had severe cognitive impairment and ambulated independently on the nursing unit. On April 23, 2024, from 12:45 p.m. through 1:05 p.m., Resident 117 was observed collecting other residents' soiled clothing protectors. At no time did staff redirect the resident. CFR 483.25(d) Accidents. Previously cited 4/26/23 28 Pa. Code 211.12(d)(1)(5) Nursing services.