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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 396074 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 09/20/2024 |
| NAME OF PROVIDER OR SUPPLIER Allied Services Skilled Nursing Center | | STREET ADDRESS, CITY, STATE, ZIP CODE 303 Smallacombe Drive Scranton, PA 18501 | |
| 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 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26142</p> <p>Based on review of clinical records and staff interview it was determined the facility failed to develop and implement a comprehensive person-centered care plan that included specific and individualized interventions to address the resident's needs for adaptive equipment to ensure the prevention of the development of potential skin impairment for one out 35 residents sampled. (Resident 250).</p> <p>Findings include:</p> <p>Clinical record review revealed Resident 250 was admitted to the facility on [DATE], with diagnoses which included down syndrome (a genetic disorder caused by the presence of all or part of a third copy of chromosome 21. It is usually associated with developmental delays, mild to moderate intellectual disability, and characteristic physical features), seizure disorder and severe intellectual disorder.</p> <p>A quarterly Minimum Data Set Assessment (MDS - a federally mandated standardized assessment conducted at specific intervals to plan resident care) dated July 13, 2024, revealed. the resident was severely, cognitively impaired, and unable to complete a BIMS test (Brief Interview for Mental Status a tool to assess the resident's attention, orientation, and ability to register and recall new information), requires extensive staff assistance for activities of daily living, and was at risk for pressure sores.</p> <p>Nursing documentation indicated Resident 250 had a history of a deep tissue injury, (a deep tissue injury, DTI, is a type of pressure ulcer that affects the subcutaneous tissues under intact skin) on April 15, 2024. Interventions to prevent pressure injury included skin prep (a protective barrier film) applied to heels as well as to apply a Truvue boot (TruVue Heel Protector is a fabric pressure care boot that mirrors the natural shape of the leg. It securely holds the leg and foot in place while allowing for full range of motion. It provides support to the foot and lower limb for pressure care and comfort, helping to reduce the risk of pressure injuries by lifting the heel off the bed and minimizing the risk of pressure injury caused by rubbing against sheets) to both heels at all times, remove every shift for a skin check. The resident's bilateral heel DTI injuries were noted to be healed on May 9, 2024.</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.

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| <p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>A review of Physicians orders dated April 15, 2024 revealed off loading (suspending the heels in the air by placing on a pillow or other device to prevent pressure), Purvue boots to bilateral lower extremities (feet) at all times, and remove the boots on every shift for skin checks.</p> <p>A review of the residents care plane dated January 4, 2024 revealed the resident was to comply with the therapeutic regimen including preventative measures to prevent the potential for skin breakdown.</p> <p>The intervention for the bilateral TruVue boots to be worn at all times, was not noted on the care plan at the time of the survey. A corresponding nurse aide Kardex (an electronic summary of the residents care utilized by nursing staff to provide appropriate care and services to residents. It lists all the important information to get a quick summary of the resident needs) did not include the daily application of the TruVue boots.</p> <p>An observation September 18, 2024 at 9 AM revealed Resident 250 was lying in bed. The bilateral Purvue boots were not on the resident's feet. The boots were noted to be on the floor, behind his bed.</p> <p>During an interview September 18, 2024 at 9:15 AM Employee 4, a nurse aide, stated she was unaware that Resident 250 was to have the Purvue boots on his feet at all times. She stated she gave Resident 250 AM care prior to this interview and put nonskid socks on the resident. She stated that she does not work on this unit very often and is not familiar with the care required for this resident. She stated at the start of the shift, she looks at the resident's Kardex to receive care instructions for the resident. She stated the Purvue boots intervention was not on the resident's Kardex at the start of the shift.</p> <p>During an interview September 18, 2024 at 9:20 AM the assistant Director of Nursing confirmed that Resident 250's pressure sore preventative intervention, the bilateral Purvue boots were not put on to his care plan at the time of the Physicians order and it was not currently on the care plan. The failed to provide documented evidence the facility developed and implemented a care plan to assure this dependent resident is provided the necessary care to prevent the potential for skin impairment.</p> <p>28 Pa Code 211.12 (d)(5) Nursing services.</p> | | |

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| <p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26142</p> <p>Based on clinical record review, facility policy review and staff interview, it was determined the facility failed to ensure that nursing services met professional standards of quality according to the Pennsylvania Code Title 49, Professional and Vocational Standards, by failing to implement nursing practices for the administration of an intravenous medication via central venous catheter for three of six residents reviewed (Resident 334, 105 and 270).</p> <p>Findings include:</p> <p>According to the Pennsylvania Code Title 49, Professional and Vocational Standards Department of State, Chapter 21 State Board of Nursing, Chapter 21.145 Functions of the LPN (Licensed Practical Nurse) requires the following:</p> <p>The LPN is prepared to function as a member of the health care team by exercising sound nursing judgement based on preparations, knowledge, skills, understandings and past experiences in nursing situations. The LPN participates in the planning, implementation and evaluation of nursing care in settings where nursing takes place. (b) The LPN administers medication and carries out the therapeutic treatment ordered for the patient in accordance with the following: (d) The Board recognizes codes of behavior as developed by appropriate practical nursing associations as the criteria for assuring safe and effective practice.</p> <p>Chapter 21.145b. IV therapy curriculum requirements;</p> <p>(f) An LPN may perform only the IV therapy functions for which the LPN possesses the knowledge, skill and ability to perform in a safe manner, except as limited under S 21.145a (relating to prohibited acts), and only under supervision as required under paragraph (1).</p> <p>(1) An LPN may initiate and maintain IV therapy only under the direction and supervision of a licensed professional nurse or health care provider authorized to issue orders for medical therapeutic or corrective measures (such as a CRNP, physician, physician assistant, podiatrist or dentist).</p> <p>(g) An LPN who has met the education and training requirements of S 21.145b (relating to IV therapy curriculum requirements) may perform the following IV therapy functions, except as limited under S 21.145a and only under supervision as required under subsection (f):</p> <p>(1) Adjustment of the flow rate on IV infusions.</p> <p>(continued on next page)</p> | | |

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| <p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>(2) Observation and reporting of subjective and objective signs of adverse reactions to any IV administration and initiation of appropriate interventions.</p> <p>(3) Administration of IV fluids and medications.</p> <p>(4) Observation of the IV insertion site and performance of insertion site care.</p> <p>(5) Performance of maintenance. Maintenance includes dressing changes, IV tubing changes, and saline or heparin flushes.</p> <p>(6) Discontinuance of a medication or fluid infusion, including infusion devices.</p> <p>(7) Conversion of a continuous infusion to an intermittent infusion.</p> <p>(8) Insertion or removal of a peripheral short catheter.</p> <p>(9) Maintenance, monitoring and discontinuance of blood, blood components and plasma volume expanders.</p> <p>(10) Administration of solutions to maintain patency of an IV access device via direct push or bolus route.</p> <p>(11) Maintenance and discontinuance of IV medications and fluids given via a patient-controlled administration system.</p> <p>(12) Administration, maintenance and discontinuance of parenteral nutrition and fat emulsion solutions.</p> <p>(13) Collection of blood specimens from an IV access device.</p> <p>A review of a facility policy for LPN's-starting/discontinuing IV's; Administering/withdrawal of IV fluids revealed, Licensed Practical Nurses who have satisfactorily completed a Board approved educational program to start and discontinue an Intravenous infusion, administer and withdraw intravenous fluids may with a written physician's order, start and discontinue an IV, administer, and withdraw IV fluids. The LPN may not administer or withdraw fluids via a venous central line (PICC line).</p> <p>The LPN (who has completed the Board certified educational program) will attend a yearly in-service of administration of intravenous fluids and medications.</p> <p>Clinical record review revealed that Resident 334 was admitted to the facility on [DATE] with diagnosis to include, orthopedic aftercare and infection, and was admitted to the facility with a PICC line (a peripherally inserted central catheter a long catheter introduced through a vein in the arm and passed through to the larger veins into the heart).</p> <p>Physicians orders dated September 11, 2024 revealed, administer Vancomycin HCl (antibiotic medication) Solution Reconstituted 750 MG, intravenously (IV) one time a day for MRSA (a type of staphylococcus bacteria that is resistant to many antibiotics) until October 18, 2024.</p> <p>(continued on next page)</p> | | |

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| <p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>A review of a September 2024 Medication Administration Record (MAR) revealed that between September 11 through September 19, 2024, Employee 26, LPN, Employee 4, LPN and Employee 6, LPN signed the MAR as administering the IV antibiotic medication to Resident 334 through the PICC line.</p> <p>Clinical record review revealed that Resident 105 was admitted to the facility on [DATE] with diagnosis to include a MRSA infection. The resident was admitted with a PICC line.</p> <p>Physicians orders dated August 22, 2024 revealed, Vancomycin HCl Intravenous Solution 1000 MG/10ML, 1750 mg intravenously every 12 hours for osteomyelitis (infection of the bone) until September, 12, 2024.</p> <p>A review of a September 2024 Medication Administration Record (MAR) revealed that between September 1 through September 12, 2024, Employee 7, LPN, Employee 8 LPN Employee 9 LPN, Employee 10 LPN, Employee 11 LPN , Employee 12 LPN, Employee 13, LPN, Employee 14, LPN, Employee 15, LPN, Employee 16, LPN, and Employee 3, LPN signed the MAR as administering the IV antibiotic medication to Resident 105.</p> <p>Clinical record review revealed that Resident 270 was admitted to the facility on [DATE] with diagnosis to include, Osteomyelitis (an infection in the bone), admitted to the facility with PICC line.</p> <p>Physicians orders dated August 15, 2024 revealed, Zosyn (an antibiotic medication Intravenous Solution 4-0.5 GM/100 ML, administer 4.5 gram intravenously every 8 hours for osteomyelitis for 32 Days</p> <p>A review of a August 2024 Medication Administration Record (MAR) revealed that between August 15 through August 31, 2024, Employee 3 LPN, Employee 17 LPN Employee 14 LPN, Employee 18 LPN, Employee 19 LPN , Employee 20 LPN, Employee 10 LPN, Employee 21 LPN, Employee 22 LPN, Employee 12 LPN, Employee 23 LPN Employee 24 LPN, Employee 15 LPN, and Employee 8 LPN signed the MAR as administering the IV antibiotic medication to Resident 270.</p> <p>Interview on September 18, 2024, at approximately 10 a.m. with Employee 11 an LPN, stated she never administered medications through residents' PICC lines at the facility. She confirmed she was never educated on the administration of medications through the PICC line. She stated she would call the RN to administer the IV through the resident's PICC line. She stated she, the LPN, would sign out on the MAR that she had administered the medication when the RN actually administered the IV medication through the resident's PICC line.</p> <p>There was no evidence of any education or supervision regarding IV administration as well as PICC line usage for any LPNs working at the facility.</p> <p>During an interview on September 20, 2024, at approximately 9:30 AM the director of nursing confirmed that LPN's in the facility did not receive education regarding the administration of medications through PICC lines. She further confirmed that as per the facility policy, only RN's were allowed to administer medications through PICC lines.</p> <p>The DON further confirmed the facility policy indicates the nurse administering the medications are to sign the MAR indicating it was administered.</p> <p><i>(continued on next page)</i></p> | | |

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| <p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>28 Pa. Code 201.20(a) Staff Development.</p> <p>28 Pa Code 211.12(5) Nursing services.</p> |

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| <p>F 0660</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Plan the resident's discharge to meet the resident's goals and needs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39929</p> <p>Based on clinical record review and resident and staff interview it was determined the facility failed to develop and implement an individualized discharge plan for one of 25 residents sampled (Resident 251).</p> <p>Findings Include:</p> <p>A review of the clinical record of Resident 251 revealed admission to the facility on [DATE], with diagnoses including heart disease.</p> <p>A quarterly Minimum Data Set Assessment (MDS- standardized assessment process conducted at periodic intervals to plan resident care) dated August 1, 2024, revealed the resident had a BIMS (brief interview to aid in detecting cognitive impairment) score of 15, indicating that her cognition was intact.</p> <p>Interview with Resident 251 on September 18, 2024, revealed the resident was hoping to return to the community to live independently.</p> <p>Review of Resident 251's comprehensive care plan revealed a focus area dated February 29, 2024, indicating the resident has been identified as a potential discharge to home and will require resident and/or caregiver training and instruction to assist with transitioning to home. This discharge plan was not revised or updated as of the time of the survey on September 20, 2024.</p> <p>A review of social service notes between Resident 251's admission February 29, 2024, and end of survey September 20, 2024, revealed no documented evidence that social services was working with the resident on a discharge plan to the community as the resident desired.</p> <p>There was no documented evidence the resident's discharge plan was updated with new goals and interventions for the resident to be discharged to the community.</p> <p>Interview with the Nursing Home Administrator on September 20, 2024, at approximately 1:30 PM confirmed the facility failed to revise and implement a discharge plan based on the resident's expressed desire to discharge to the community.</p> <p>28 Pa. Code 201.25 Discharge policy.</p> | | |

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| <p>F 0694</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>Provide for the safe, appropriate administration of IV fluids for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43944</p> <p>Based on observations, review of select facility policy and clinical records, and staff interviews it was determined the facility failed to provide person-centered care as prescribed to meet the current clinical needs, and failed to follow physician orders for management of a PICC line for two residents out of 35 sampled (Residents 270, and 105).</p> <p>Findings include:</p> <p>Review of the facility policy titled Central Venous Catheter/PICC Care/Flush/Medication Administration last reviewed by the facility on July 24, 2024, revealed that it is the policy to provide dressing changes, medication and flushes to residents with a central venous catheter (CVC) or peripherally inserted central catheter (PICC a long catheter introduced through a vein in the arm, then through the subclavian vein into the superior vena cava or right atrium of the heart to administer parenteral fluids). Dressing changes are to be done weekly and PRN (as needed) with the extension tubing, stabilization device and cap change unless ordered otherwise by the physician. The dressing change is to be done by a Registered Nurse. During all dressing changes, assess the external length of the catheter to determine if migration (movement out of position) of the catheter has occurred. PICC external length is measured on admission or at the time of insertion, if after admission and documented on the care plan. Migration of any PICC line requires physician notification.</p> <p>A review of the clinical record revealed Resident 270 was admitted to the facility on [DATE], with diagnoses to include osteomyelitis (inflammation of the bone caused by an infection), and immunodeficiency (failure or absence of elements of the immune system to fight infectious diseases).</p> <p>Review of Resident 270's hospital record dated August 8, 2024, revealed the resident underwent a procedure for a single lumen PICC placement in his left arm. The catheter (tubing) total length was 42 cm (no external catheter length was noted in the hospital records provided by the facility). The reason indicated for the PICC line was IV therapy for antibiotics.</p> <p>A review of physician orders dated August 15, 2024, revealed an order to change the PICC dressing weekly to include site care/extension tubing change/cap change/stabilization device every 7 days during day shift. The external length of catheter was to be measured during the dressing change or as needed (an increase in the external catheter length may indicate a problem with the PICC line).</p> <p>A review of Resident 270's plan of care, initially dated August 15, 2024, indicated that the resident required a PICC line. The PICC line external length measured 0 (zero) cm.</p> <p>Review of Resident 270's Medication Administration Record (MAR) for August 16, 2024, revealed nursing staff documented an X for the external catheter length measurement and documented a 7 above the nurse initials (according to the MAR coding, a 7 is not applicable). On August 20, 2024, nursing staff documented an external catheter length of 2 cm.</p> <p>Review of Resident 270's MAR for September 2, 2024, revealed that nursing staff documented an external catheter length of 1.5 cm.</p> <p>(continued on next page)</p> | | |

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| <p>F 0694</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>There was no documented evidence in the MAR or progress notes for the months of August and September 2024, that a weekly dressing change and external catheter length measurement was performed weekly as ordered.</p> <p>There was no documented evidence the physician was notified of the change in the measurement of the external catheter length from 0 cm on August 15, 2024, to 2 cm on August 20, 2024, and to 1.5 cm on September 2, 2024.</p> <p>Interview with the Director of Nursing on September 20, 2024, at approximately 9:40 AM was unable to provide documented evidence the facility performed weekly PICC dressing changes and measurement of the external catheter length as ordered by the physician. The DON confirmed there was no documented evidence that the physician was notified of the change in the external catheter length documented on August 20, 2024, and September 2, 2024.</p> <p>A review of Resident 105's clinical record revealed the resident was readmitted to the facility on [DATE], with diagnoses that include right AKA (above the knee) amputation (is a removal of all or a portion of a limb due to chronic disease or a traumatic injury), osteomyelitis (bone infection) right distal femur (thigh bone above the knee), and sepsis (is a potentially life-threatening condition that arises when the body's response to infection causes injury to its own tissues and organs).</p> <p>A review of Resident 105's readmission nursing evaluation completed by Employee 16, a licensed practical nurse (LPN), dated August 22, 2024, at 2:20 PM, revealed the resident returned to the facility with a peripherally inserted central catheter line in the right arm that was clean, dry, and intact.</p> <p>A review of physician's orders dated August 22, 2024, at 4:24 PM, indicated to change PICC dressing weekly with site care ,extension tubing change, cap change and stabilization device. May change dressing PRN (as needed) every day shift every 7 day(s) and measure the external length of catheter.</p> <p>A review of the resident's comprehensive person-centered plan of care that was initiated on August 23, 2024, identified the resident required a PICC line to the right upper arm, length: 46 cm, exposure: 0 cm(zero) with a resident goal it will remain patent and free of complications through next review. Planned interventions included to change dressing per policy or as ordered by physician and measure PICC line length if removing.</p> <p>A review of Resident 105's Medication Administration Record (MAR) dated August 22, 2024, through survey ending September 20, 2024, revealed the physician ordered weekly PICC line dressing changes and site care and external catheter length measurement were blank (no recorded documentation by staff) on August 23, 2024, and August 30, 2024, and September 6, 2024.</p> <p>The facility could not provide documented evidence that nursing staff completed physician ordered PICC line treatments or measurements as ordered.</p> <p>An interview with the Director of Nursing (DON) on September 20, 2024, at 9:40 AM, confirmed the facility could not provide documented evidence that PICC line treatments were performed and that the external catheter length was measured as ordered by Resident 105's prescribing physician.</p> <p>28 Pa. Code 211.12 (c)(d)(1)(3)(5) Nursing services.</p> | | |

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| <p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48277</p> <p>Based on review of clinical records, observation, and staff interview, it was determined the facility failed to follow physician orders for oxygen therapy and failed to to maintain oxygen equipment in a functional and sanitary manner for two residents out of 35 sampled (Residents 227 and 176).</p> <p>Findings include:</p> <p>Review of Resident 227's clinical record revealed the resident was admitted to the facility on [DATE], with diagnoses to include respiratory failure (not enough oxygen passes from the lungs to the blood, making it difficult to breathe), and dependence on supplemental oxygen (treatment that provides extra oxygen to breathe).</p> <p>The resident had a current physician's order, initially dated August 28, 2024, for continuous oxygen therapy administration via nasal canula (flexible plastic tubing with small prongs inserted into the nostrils to deliver supplemental oxygen) at three (3) liters per minute.</p> <p>An observation conducted on September 17, 2024, at 1:20 PM revealed that Resident 227 was lying in bed with supplemental oxygen in place via an oxygen concentrator (bedside machine that concentrates ambient air to supply an oxygen-rich gas stream) with the liter flow set at 2 liters per minute.</p> <p>An additional observation made on September 18, 2024, at 12:40 PM revealed that Resident 227 was lying in bed with supplemental oxygen in place via an oxygen concentrator with the liter flow set at 2 liters per minute.</p> <p>Interview with Employee 1 (licensed practical nurse) at the time of the observation on September 18, at 12:40 PM confirmed that Resident 227 was prescribed three (3) liters of oxygen continuously, but the resident was currently receiving 2 liters of oxygen per minute.</p> <p>Review of Resident 176's clinical record revealed the resident was admitted the facility on June 24, 2020, with diagnoses to include acute respiratory failure, and pneumonia (infection that inflames air sacs in one or both lungs, which may fill with fluid or pus and cause breathing difficulties).</p> <p>The resident had a physician's order, initially dated August 26, 2024, for Ipratropium-Albuterol Solution 0.5-2.5 (3) MG/3ML (medication inhaled into the lungs using a nebulizer machine which is a small machine that turns liquid medicine into a mist that can be inhaled into the lungs) inhale orally via nebulizer four times a day for expiratory wheeze for 7 days. The physician's order end date for the nebulizer treatment was September 2, 2024.</p> <p>An observation conducted on September 17, 2024, at 1:46 PM revealed that Resident 176 was awake and lying in bed. The resident's nebulizer machine, including the tubing and mouthpiece, were placed on the bedside nightstand. Also present on the bedside nightstand were opened beverages and snack containers, pepper packets, toiletries, a reacher (adaptive device used to assist with picking up objects) and a telephone. The nebulizer mouthpiece was uncovered and not bagged.</p> <p>(continued on next page)</p> | | |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 396074 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 09/20/2024 |
| NAME OF PROVIDER OR SUPPLIER Allied Services Skilled Nursing Center | | STREET ADDRESS, CITY, STATE, ZIP CODE 303 Smallacombe Drive Scranton, PA 18501 | |
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| <p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Interview with the Director of Nursing (DON) on September 19, 2024, at 10:14 AM confirmed that residents' respiratory equipment and supplies should be bagged when not in use to prevent contamination. The facility failed to maintain oxygen delivery equipment in a sanitary manner.</p> <p>28 Pa. Code 211.12 (d)(1)(3)(5) Nursing services.</p> <p>28 Pa. Code 211.10 (a)(c) Resident Care Policies.</p> | | |

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| <p>F 0699</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Provide care or services that was trauma informed and/or culturally competent.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39929</p> <p>Based on a review of clinical records and staff interview, it was determined that the facility failed to develop and implement an individualized person-centered plan to render trauma informed care to a resident with a diagnosis of Post-Traumatic Stress Disorder for one out of 35 residents reviewed (Resident 156).</p> <p>Findings include:</p> <p>A review of the clinical record revealed Resident 156 was admitted to the facility on [DATE], with diagnoses that included Post Traumatic Stress Disorder (PTSD).</p> <p>The resident's current care plan, in effect at the time of review on September 20, 2024, did not identify the resident's PTSD (a mental and behavioral disorder that develops related to a terrifying event) symptoms or triggers related to this diagnosis and resident specific interventions to meet the resident's needs for minimizing triggers and/or re-traumatization.</p> <p>The facility failed to develop and implement an individualized person-centered plan to address, this resident's diagnosis of PTSD according to standards of practice to promote the resident's emotional well-being and safety.</p> <p>Interview with the Director of Nursing on September 20, 2024, at 10:00 AM confirmed the facility was unable to demonstrate the facility provided culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for resident's experiences and preferences to eliminate or mitigate triggers that may cause re-traumatization of the resident.</p> <p>28 Pa Code 211.12 (d)(3)(5) Nursing services.</p> |

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| <p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>43944</p> <p>Based on review of select facility policy, observation, and staff interview it was determined the facility failed to store drugs and pharmacy supplies in a safe manner and failed to remove medications awaiting final disposition in a timely manner in three medication storage rooms out of five medication storage rooms first floor, second floor, north, and third floor, south.</p> <p>Findings include:</p> <p>Review of facility policy titled Disposition of Medications: Discontinued Medications last reviewed by the facility July 24, 2024, indicated that medications discontinued by physician order, a resident is transferred or discharged and does not take the medication with him/her, or in the event of resident's death, the medications are marked as discontinued with a label closure. If a prescriber discontinues a medication, the medication container is marked appropriately (e.g. with a stop drug sticker) and the date of discontinuation is indicated along with the name of the nurse. Medications awaiting disposal or return are stored in a locked secure area designated for that purpose until destroyed or picked up for destruction by the pharmacy.</p> <p>Observation of the first floor medication storage room conducted on September 18, 2024, at 11:04 AM, in the presence of Employee 2 (registered nurse) revealed a clear storage bin on the countertop overflowing with discontinued resident prescription medication cards, pill packages, nebulizer treatments, vials of medications (heparin), IV bags, bottles of liquid medication, and insulin pens that were left unsecured.</p> <p>Interview with Employee 2 on September 18, 2024, at 11:15 AM, confirmed the prescription medications in the bin were discontinued medications removed from the medication carts and awaiting pharmacy pickup. Employee 2 was unsure of the procedure or frequency for pharmacy pickup.</p> <p>Observation of the second floor (2 North) medication storage room conducted on September 18, 2024, at 11:54 AM, revealed a clear storage bin, on the floor behind the door, with discontinued resident prescriptions of medication cards, pill packages, nebulizer treatments, and an IV bags that were left unsecured.</p> <p>An interview with Employee 27, a registered nurse (RN), on September 18, 2024, at 11:57 AM, confirmed the medications in the bin were discontinued medications awaiting pickup from the pharmacy.</p> <p>Observation of the third floor medication storage room (3 South) conducted on September 18, 2024, at 1:00 PM revealed a blue storage bin on the countertop overflowing with discontinued resident prescriptions lidocaine patches, medication cards, pill packages, nebulizer treatments, IV bags, bottles of liquid medication, and prescription lotions that were left unsecured.</p> <p>Interview with Employee 3 (licensed practical nurse) on September 18, 2024, at 1:15 PM confirmed the medications in the bin were discontinued medications awaiting pickup from pharmacy.</p> <p>(continued on next page)</p> | | |

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| <p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>During an interview with the Director of Nursing (DON) on September 19, 2024, at 10:20 AM she confirmed that discontinued medications should have been returned to pharmacy in a timely manner and the medications should have been stored in a secured manner to prevent unauthorized access and the potential for drug diversion.</p> <p>28 Pa. Code 211.9 (a)(1)(k) Pharmacy Services</p> <p>28 Pa. Code 211.12 (d)(3)(5) Nursing services.</p> | | |

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| <p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26142</p> <p>Based on observations and staff interview, it was determined the facility failed to maintain infection control practices to prevent the spread of infection for one of 35 sampled residents. (Resident 337)</p> <p>Findings include:</p> <p>An observation September 18, 2024 at 9:20 AM revealed Resident 337 lying in bed. His supra pubic (a medical device that drains urine from the bladder through a small incision in your abdomen into a plastic bag) and tubing was directly on the floor.</p> <p>Observation September 17, 2024 at 11:11 AM, revealed a soiled brief was on top of the clean linen cart located outside of room [ROOM NUMBER]-N. The brief was malodorous.</p> <p>Observation September 19, 2024 at 9:05 AM, in room [ROOM NUMBER]-N, seven clean briefs were directly on the floor next to the residents bedside table.</p> <p>In room [ROOM NUMBER], three heel lift boots were directly on the floor behind the residents bedside table. There was a box of tube feeding bottles directly on the floor next to the bedside table.</p> <p>In room [ROOM NUMBER]-N there were four boxes of briefs and bed pads directly on the floor. Two of the boxes were noted to be open with the bags of clean briefs and bed pads open to the air.</p> <p>In room [ROOM NUMBER]-N there were three open boxes of briefs directly on the floor and two opened plastic bags with clean briefs on top of the boxes.</p> <p>During an interview with the Director of Nursing on September 19, 2023, at 10 AM, it was confirmed that resident care equipment should be stored in a sanitary manner.</p> <p>28 Pa. Code 211.12 (5) Nursing services</p> <p>28 Pa. Code 201.18 (1) Management.</p> |