STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	396095	A. Building B. Wing	11/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Scranton Health Care Center	2933 McCarthy Street Scranton, PA 18505

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26142 Based on a review of the facility's abuse prohibition policy and procedures and facility documentation and staff interview, it was determined that the facility failed to implement measures to deter misappropriation of resident property by failing to thoroughly investigate potential misappropriation of resident property for two of 14 residents sampled (Resident 9 and 90). Findings include: A review of a facility policy for Abuse, neglect and exploitation reviewed July 2024 revealed, It is the facility's policy to investigate all allegations, suspicions and incidents of abuse, neglect, involuntary seclusion, intimidation, exploitation of residents, misappropriation of resident property and injuries of unknown injury. Staff must immediately report all such allegations to the administrator/abuse coordinator. The administrator will immediately begin an investigation and notify the applicable local and state agencies in accordance with this policy. Clinical record review revealed Resident 9 was admitted to the facility on [DATE], with diagnoses to include cerebral infarction (stroke), and pain in the right shoulder. An admission MDS (Minimum Data Set - a federally mandated standardized assessment conducted at specific intervals to plan resident care) dated August 19, 2024, revealed that Resident 9 was cognitively intact with a BIMS score of 13 (a quick snapshot of how well you are functioning cognitively at the moment, a score of 13-15 indicate cognitively intact), independent for activities of daily living and received opioid pain medication. The resident had a current physician order dated February 2, 2024, for Oxycodone 5 mg (a narcotic opiod pain medication) one, by mouth every 4 hours as needed for moderate-severe pain rated) and give one tab by mouth every 4 hours as needed for severe pain. A review of narcotic sign out records dated February and March 2024 for Resident 9's Oxycodone 5 mg, by mouth every 4 hours as needed for severe pain revealed that from February 10, 2024 and March 25, 2024, 24 of the 30 doses of the narcotic pain medication were signed out as given on the 11 P.M. to 7 A.M. shift. (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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The resident's July 2024 individual resident controlled substance record accounting for Resident 9's supply of the controlled drug, and nursing staff's removal of doses for administration of Oxycodone 5 mg revealed that Employee 2 (LPN) signed out doses of the controlled drug for administration to the resident on the following dates and times: July 4, 2024, at 1:30 AM July 11, 2024, - 5:30 AM July 19, 2024, - 2 AM A review of facility nurse staffing punch detail report for Employee 2 (LPN), signed the above noted narcotic pain medication doses as given to the resident on the narcotic drug. Employee 2 (LPN) was not on duty at the facility on the above noted dates. In addition, these doses were not signed out on the medication administration record (MAR). The resident's August 2024 individual resident controlled substance record accounting for Resident 9's supply of the controlled drug, and nursing staff's removal of doses for administration of Oxycodone 5 mg revealed that Employee 2 (LPN) signed out doses of the controlled drug for administration to the resident on the following dates and times: August 8, 2024, at 1 AM August 13, 2024, -12:30 AM August 15, 2024, - 1 AM August 22, 2024, - 1:30 AM A review of an August 2024 MAR, the above noted doses were not signed out on the medication administration record (MAR) as given to the resident. Clinical record review revealed that Resident 90 was admitted to the facility on [DATE] with diagnosis to include, hypertension, diabetes and on hospice services. A quarterly MDS dated [DATE] revealed the resident's BIMs score as 13, cognitively intact, required staff assistance for activities of daily living and had pain, receiving as needed pain relief. The resident had a physician's order dated April 29, 2024, for Hydrocodone-Acetaminophen 7.5-300 mg (a narcotic, opiod/non narcotic pain medication combination) one, by mouth every 6 hours as needed for severe pain rated. A Physician's order dated July 12, 2024 revealed to discontinue the Hydrocodone-Acetaminophen 7.5-300 mg, one by mouth every 6 hours as needed for severe pain. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The resident's individual resident controlled substance record accounting for Resident 90's supply of the controlled drug, and nursing staff's removal of doses for administration of Hydrocodone-Acetaminophen 7.5-300 mg revealed that Employee 2 (LPN) signed out doses of the controlled drug Hydrocodone-Acetaminophen 7.5-300 mg for administration to resident 90 on the following dates and times: July 19, 2024, at 5 AM July 23, 2024, - 5:30 AM July 24, 2024, - 5:30 AM July 25, 2024 - 2:30 AM The resident's individual resident controlled substance record accounting for Resident 90's supply of the controlled drug revealed, Employee 6 (agency RN) signed out a dose of the Hydrocodone-Acetaminophen 7.5-300 mg on July 19, 2024 at 4 P.M. None of the above noted doses of the narcotic pain medication were documented as given on the narcotic reconciliation record, however were not signed out on the MAR. The Physician ordered narcotic pain medication order was discontinued on July 12, 2024 and 5 doses of the medication were documented as administered as given after the medication was discontinued. During an interview, October 31, 2024 at 1 P.M., the Nursing Home Administrator confirmed that narcotic pain medications were not administered as per facility policy and procedure. A review of a facility policy for Resident Abuse, adopted by the facility July, 2024 revealed, The facility will not tolerate abuse, neglect, mistreatment, exploitation of residents and misappropriation of resident property by anyone. A review of a facility investigation dated August 26, 2024 at 8:30 A.M., revealed that on August 26, 2024 (no time indicated) Employee 5 (RN supervisor) reported to the ADON (assistant Director of Nursing) that she and Employee 4(LPN) noticed suspicious activity with Employee 2 (LPN) with her deliverance of narcotics. The ADON immediately notified the DON. The investigation revealed inconsistences with Resident 9's as needed narcotic pain medication administration. Both nurses Employee 5 (RN supervisor) and 4 (LPN) stated that every shift Employee 2 (LPN) worked, she administered Resident 9's oxycodone 5 mg at 1:30 A.M. with the pain scale as 7 out of 10. When Employee 2 (LPN) was not working, Resident 9 did not complain of pain. Resident 9 typically did not request assistance or ask for pain medication on the 11 P.M. to 7 A.M. shift. The investigation continued to note that narcotic pain medication was given to Resident 90 without a current Physician's order. A urine drug test was administered and was positive for Oxycodone. Employee 2 (LPN) was immediately suspended (August 26, 2024) and the facility is awaiting the outcome of the outside investigatory agency's investigation, to terminate Employee 2 (LPN). (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of a witness statement dated August 27, 2024 (no time indicated) Employee 5 (RN supervisor) stated, On Thursday August 22, 2024, Employee 4 (LPN) pointed out that Employee (2 LPN) was medicating Resident 9 every night (11 P.M. to 7 A.M. shift) shift that she worked. Employee 4 (LPN) stated that she asked Resident 9, during a shift that she worked, if she needed anything for pain. Resident 9 replied no. Resident 9 never requested pain medication during my shifts (11 P.M. to 7 A.M.). On Sunday August 25, 2024 during the 11 P.M. to 7 A.M. shift, Employee 2 (LPN) stated that Resident 90's Hydrocodone was discontinued. After reviewing Resident 9's MAR, it was noted that oxycodone was given at the same time on the night shift, every shift that Employee 2 (LPN) worked. It was also noted Resident 90's Hydrocodone was previously discontinued and Employee 2 (LPN) 4 doses of the narcotic medication was signed out on the narcotic medication record and not on the MAR after the narcotic was discontinued by the Physician. At the end of my shift, I spoke to the ADON about my concerns. A review of a witness statement dated August 25, 2024 (no time indicated) the ADON stated that she was approached in the parking lot by Employee 5 (RN supervisor). She stated that Employee 2(LPN) was sneaky. She stated that every shift Employee 2 (LPN) works, she administered an Oxycodone 5 mg pill to Resident 9 between 1 and 2 A.M. The nursing supervisor stated between this time frame, Resident 9's call bell is not lit. She stated that Employee 2 (LPN) is either asleep, watching a movie on her phone while the resident is asleep. Employee 5 (RN SUPERVISOR) asked the ADON, at that time not to tell anyone about this until this is further evaluated. The DON was alerted. A review of a witness statement dated August 26, 2024 (no time indicated) Employee 2 (LPN) stated that she gave pain meds to residents when they asked. Sometimes she will ask if they (residents) have pain. Resident 90 would ask for pain meds. She stated that she realized after the fact that her narcotic medication was previously discontinued. When she was told, she was working by herself at night. The facility failed to demonstrate that a timely, complete and thorough investigation had been conducted into the misappropriation of the resident's narcotic medication. During an interview October 31, 2024 the Director of Nursing and the Nursing Home Administrator confirmed that the allegations of misappropriation of resident property)narcotic medication) was not timely reported to facility administration and an investigation was not initiated timely. They confirmed the misappropriation of resident property related to narcotic medications. 28 Pa Code 211.9 (a)(1)(j.1)(k) Pharmacy services. 28 Pa. Code 201.29(a)(c) Resident rights 28 Pa. Code 201.18(e)(1) Management 29 Pa. Code 211.10(c) Resident care policies

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F 0623 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39929 Based on a review of clinical records and facility-initiated transfer notices and a staff interview, it was determined the facility failed to provide written notices of facility-initiated hospital transfers to the resident and their representative and failed to provide a copy of the notices to a representative of the Office of the State Long-Term Care Ombudsman for two residents out of the 14 sampled (Residents 9 and 23). Findings include: Regulatory requirements indicate that before a facility transfers or discharges a resident, the facility must notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. A review of Resident 9's clinical record revealed the resident was initially admitted to the facility on [DATE], with diagnoses that included osteoarthritis (a type of degenerative joint disease that results from breakdown of joint cartilage and underlying bone) and muscle weakness. A review of the clinical record revealed that Resident 9 was transferred to the hospital on July 20, 2024, and was readmitted to the facility on [DATE]. A review of the clinical record failed to reveal documented evidence the facility provided the resident and resident responsible party (RP) with a written notice of the facility-initiated transfer and reason for the transfer on July 20, 2024. Additionally, the facility could not provide documented evidence that a copy of the transfer notice was provided to a representative of the Office of the State Long-Term Care Ombudsman. A review of Resident 23's clinical record revealed the resident was initially admitted to the facility on [DATE] with diagnoses that included diabetes. A review of the clinical record revealed that Resident 23 was transferred to the hospital on September 21, 2024, and was readmitted to the facility on [DATE]. A review of the clinical record failed to reveal documented evidence the facility provided the resident and resident responsible party (RP) with a written notice of the facility-initiated transfer and reason for the transfer on September 21, 2024. During an interview with the Director of Nursing (DON) on October 31, 2024, at 2:30 PM, confirmed the facility had no documented evidence that Resident 9's and Resident 23's RP's were provided with a written notice of the facility initiated transfer that was initiated on July 20, 2024, and the facility could not provide documentation that a copy of the transfer notice was provided to a representative of the Office of the State Long-Term Care Ombudsman. 28 Pa. Code 201.14(a) Responsibility of licensee.

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F 0625 Level of Harm - Potential for minimal harm Residents Affected - Some	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39929 Based on a review of clinical records and select facility policy, staff and resident interviews, it was determined the facility failed to provide written notice of the facility's bed hold policy to a resident and the resident's representative upon the resident's transfer to the hospital for two residents out of 14 sampled (Residents 9 and 23). Findings included: A review of the clinical record revealed that Resident 9 required transfer to the hospital on July 20, 2024, and was readmitted to the facility on [DATE]. Further clinical record review revealed no documentation that Resident 9 or Resident 9's responsible party (RP) were made aware of a facility's bed-hold and reserve bed payment policy upon transfer to the hospital. A review of the clinical record revealed that Resident 23 was transferred to the hospital on September 21, 2024, and was readmitted to the facility on [DATE]. Further clinical record review revealed no documentation that Resident 23 or Resident 23's RP were made aware of a facility's bed-hold and reserve bed payment policy upon transfer to the hospital. During an interview on October 31, 2024, at approximately 2:30 PM, the Nursing Home Administrator (NHA) and Director of Nursing (DON) were unable to provide evidence the facility made Residents 9 and Resident 23 and their RP's aware of the facility's bed-hold and reserve bed payment policy upon transfer to the hospital. 28 Pa. Code 201.29 (a)(c.3)(2) Resident rights

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Plan the resident's discharge to meet the resident's goals and needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39929 Based on a review of clinical records and staff interviews it was determined the facility failed to develop and implement an individualized discharge plan for one of 14 residents reviewed (Resident 33) to reflect the resident's discharge goals. Findings Include: Clinical record review revealed that Resident 33 was admitted to the facility on [DATE], with diagnoses to include dementia (a term for loss of memory, language and other thinking abilities that interfere with daily life). Review of an admission Minimum Data Set Assessment (MDS- a federally mandated standardized assessment process completed at specific intervals to plan resident care) dated August 21, 2024, indicated the resident had a BIMS (brief interview mental screener that aids in detecting cognitive impairment) score of 14 indicating she was cognitively intact. A review of Resident 33's social service notes, revealed a note dated September 30, 2024, indicating the resident would like to be discharged home when able. There were no further social service notes regarding discharge from the facility. A review of the resident's comprehensive care plan, reviewed during the survey ending November 1, 2024, revealed no documented evidence that an individualized discharge plan was developed, and revised, as needed to reflect the resident's current desire for discharge or long-term placement at the facility. During an interview with the Director of Nursing on October 31, 2024, at 12:00 PM confirmed there was no documented evidence of a current discharge goal and plan for this resident. 28 Pa. Code 201.25 Discharge policy. 28 Pa. Code 211.11(d)e Resident care plan.

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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** 43944 Based on a review of clinical records, observations and staff and resident interview it was determined the facility failed to to demonstrate the consistent implementation of measures planned to prevent pressure sore development for one resident out of 14 sampled (Residents 34). Findings include: According to the US Department of Health and Human Services, Agency for Healthcare Research & Quality, the pressure ulcer best practice bundle incorporates three critical components in preventing pressure ulcers: Comprehensive skin assessment, Standardized pressure ulcer risk assessment and care planning and implementation to address the areas of risk. The American College of Physicians (ACP) is a national organization of internists, who specialize in the diagnosis, treatment, and care of adults. The largest medical-specialty organization and second-largest physician group in the United States) Clinical Practice Guidelines indicate that the treatment of pressure ulcers should involve multiple tactics aimed at alleviating the conditions contributing to ulcer development (i. e. support surfaces, repositioning and nutritional support); protecting the wound from contamination and creating and maintaining a clean wound environment; promoting tissue healing via local wound applications, debridement and wound cleansing; using adjunctive therapies; and considering possible surgical repair. A review of Resident 34's clinical record revealed the resident was admitted to the facility on [DATE], with diagnoses that included traumatic subarachnoid hemorrhage (bleeding in the space that surrounds the brain) without loss of consciousness, Alzheimer's disease (is a general term describing problems with reasoning, planning, judgment, memory and other thought processes caused by brain damage from impaired blood flow to the brain), dysphagia (difficulty swallowing), aphasia (inability to speak), and protein-calorie malnutrition. Resident 34's Significant Change Minimum Data Set (MDS - is a federally mandated standardized assessment conducted periodically to plan resident care) assessment dated [DATE], was coded to indicated the resident had a BIMS score (Brief Interview for Mental Status is a tool used to evaluate cognitive impairment and assist with dementia diagnosis) of 02 which indicated the resident had severe cognitive impairment. Additionally, Section GG, Functional Abilities and Goals, of the MDS was coded that Resident 34 was dependent (helper does ALL of the effort, resident does none of the effort to complete the activity, or the assistance of two or more helpers required for the resident to complete the activity) for ADL's (activities of daily living, transfers, bed mobility, eating, bathing, toileting, and toilet hygiene). The resident was totally incontinent of bladder and bowel. A review of Resident 34's clinical record revealed that Employee 1, a Registered Nurse (RN), completed a wound observation entry indicating a re-opening of MASD (moisture associated skin damage - refers to inflammation or skin erosion caused by prolonged exposure to moisture from sources such as urine, stool, sweat, wound drainage, saliva, or mucus) dated July 16, 2024, at 12:59 PM, but the MASD was identified on July 15, 2024, at 6:58 PM. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of nurses' notes in the clinical record revealed a note written by Employee 1, RN dated July 16, 2024, at 1:06 PM, revealed that a new area to Resident 34's left buttock was observed during care. The area was assessed and identified as a re-opening of MASD (moisture associated skin damage - refers to inflammation or skin erosion caused by prolonged exposure to moisture from sources such as urine, stool, sweat, wound drainage, saliva, or mucus). The area measured 2.0 centimeters (cm) in length by 2.0 cm in width. A call was placed to the PCP (primary care practitioner) with NON (new orders noted) for a treatment to left buttock. The facility could not provide documented evidence that preventative measures were in place and completed to deter/prevent a re-opening of MASD of Resident 34's left buttocks. Additionally, the facility could not provide documented evidence the reopened area to the left buttocks was investigated and that appropriate interventions were developed and implemented to deter further skin breakdown. Further review of a nurses' note completed by Employee 1, dated July 23, 2024, 4:42 PM, revealed the hospice nurse was in to provide care to Resident 34 and observed a discoloration to the resident's sacrum. Employee 1, RN assessed and noted a non-blanchable (occurs when skin remains red after pressing and means that there is little or no blood flow going to that area) area measuring 2.8 cm in length by 2.5 cm in width with the surrounding tissue pink in color. An air overlay mattress (used to reduce pressure and development of pressure ulcers and other skin impairments), heel bows (relieves points of pressure to an individual's heels), pillow separating BLE's (bilateral lower extremities) were all in place. The resident's Broda chair contained a pressure reducing surface. PCP and Hospice made aware of assessment findings, current interventions, and new interventions and in agreement with same. New interventions include, but are not limited to, wound care consult, treatment to affected area, limited time OOB (out of bed), replacement of air overlay mattress to full alternating air mattress, dietary consult, and weekly and prn (as needed) wound assessment. Further review of a wound observation completed by Employee 1, RN and dated August 1, 2024, at 9:12 AM, revealed the unstageable/deep tissue area to the sacrum was assessed on July 31, 2024 with the facility's contracted wound care consultants/practitioners and indicated the area was opened and now a Stage 3 pressure ulcer (opened through the second layer of skin into the fat tissue with symptoms that include a crater appearance, may have a foul odor, and may show signs of infection such as red edges, pus, odor, heat, and/or drainage with the tissue in or around the sore appearing black indicating dead tissue) measured 2.0 cm in length by 1.5 cm in width with 0.2 cm in depth with a light amount of serosanguineous (pale red to pink, thin and watery) exudate, no odor, with 75-percent granulation tissue covering the wound, and 24-percent of the wound covered with slough (a type of necrotic tissue that accumulates on the surface of a wound) with the edge attached to base. Further review of the wound observation indicated that preventative measures were in place such as a low loss air mattress, turn and reposition program, bilateral heel bows, barrier cream, Broda chair with pressure reducing cushion, and Prostat (a high protein nutrition supplement). The treatment was changed to Medi Honey (skin treatment that supports wound healing by drawing out fluid and maintaining optimal pH for wound management) twice per day and prn for soilage/dislodgement. Resident 34's clinical record failed to reveal documented evidence that preventative measures, such as turning and repositioning were implemented and performed prior to the identification of the sacral pressure ulcer. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Additionally, the resident's comprehensive person-centered plan of care failed to specify individualized interventions to prevent the development of skin impairments such as MASD and pressure ulcers. During interviews with the Director of Nursing (DON) and in the presence of the Nursing Home Administrator (NHA) on November 1, 2024, at 10:36 AM, it was revealed that some of Resident 34's preventative measures for pressure ulcer/skin preventions such as turning and repositioning, checking and changing, and skin prep post incontinent episodes, to prevent skin impairments were not carried over from the previous EHR (electronic health record system) to the newly implemented EHR that was implemented mid-May 2024. Further interview with the DON and NHA confirmed the facility could not provide documented evidence that effective pressure ulcer/MASD interventions were in place prior to identification of the MASD to the left buttocks and unstageable/deep tissue area to the sacrum that opened into a Stage 3 pressure ulcer. Additionally, it was confirmed the resident's comprehensive person-centered plan of care was not fully developed with effective pressure ulcer prevention/skin impairment measures to deter skin impairments/pressure ulcers from developing. 28 Pa. Code 211.5(f)(vii) Medical records 28 Pa. Code 211.12(c)(d)(1)(3)(5) Nursing services.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26142 Based on a review of clinical records, select facility policy and staff interviews it was determined the facility failed to develop and implement individualized measures for the toileting needs of three residents out of 14 sampled residents for bowel and bladder management (Residents 19, 34, and 20). Findings included: A review of a facility policy entitled Continence Management Program that was last reviewed by the facility on October 28, 2024, indicated the facility would develop a plan designed to manage incontinence according to the resident's needs and capabilities. Upon admission, the admitting Nurse will complete a head-to-toe assessment which includes interview of the resident and review of underlying conditions that may affect the resident's ability to participate in a continence management program. A Continence Evaluation will be conducted to determine if a 72-hour bowel and bladder tracking program is indicated. If tracking is indicated, the licensed nurse will instruct the nursing assistants to fill out a form. When a pattern has been identified, a new continence evaluation will be completed, and the licensed nurse will develop a toileting plan and determine the approaches needed to achieve the goals. The licensed nurse will review the plan as needed to identify any necessary modifications. A review of Resident 34's clinical record revealed the resident was admitted to the facility on [DATE], with diagnoses that included traumatic subarachnoid hemorrhage (bleeding in the space that surrounds the brain) without loss of consciousness, Alzheimer's disease (is a general term describing problems with reasoning, planning, judgment, memory and other thought processes caused by brain damage from impaired blood flow to the brain), dysphagia (difficulty swallowing), aphasia (inability to speak), and protein-calorie malnutrition. A review of Resident 34's Significant Change Minimum Data Set (MDS - is a federally mandated standardized assessment process conducted periodically to plan resident care) assessment dated [DATE], was coded to indicated the resident had a BIMS score (Brief Interview for Mental Status is a tool used to evaluate cognitive impairment and assist with dementia diagnosis) of 02, which indicated the resident had severe cognitive impairment. Additionally, Section GG, Functional Abilities and Goals, of the MDS was coded to indicate Resident 34 was dependent (helper does ALL of the effort, resident does none of the effort to complete the activity, or the assistance of two or more helpers required for the resident to complete the activity) for ADL's (activities of daily living, transfers, bed mobility, eating, bathing, toileting, and toilet hygiene). The resident was totally incontinent of bladder and bowel and was not on a toileting management program. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the clinical record revealed an Elimination - Continence and Retraining/Scheduled Toileting and Decision/Determination completed by Employee 3, a Licensed Practical Nurse (LPN), dated May 26, 2024, at 2:39 PM, revealed Resident 34 had a terminal illness and that based on review, the resident appears to be a good candidate for bowel and/or bladder retraining and selected a scheduled bowel/bladder program. Additionally, Employee 3, LPN described the toileting program details as per POC (plan of care) and to continue with the current plan of care. However, the Elimination - Continence and Retraining/Scheduled Toileting and Decision/Determination form failed to be fully completed and Resident 34's comprehensive person-centered plan of care failed to indicate incontinence management needs. A review of nurses' notes in the clinical record revealed noted by Employee 1, RN dated July 16, 2024, at 1:06 PM, revealed that a new area to Resident 34's left buttock was observed during care. The area was assessed and identified as a re-opening of MASD (moisture-associated skin damage or MASD is defined as inflammation and erosion of the skin caused by prolonged exposure to moisture and its contents, including urine, stool, perspiration, wound exudate, mucus, or saliva. A wound assessment was completed, and call placed to PCP (primary care practitioner) with NON (new orders noted) for a treatment to left buttock. Resident 34's clinical record failed to reveal documented evidence that a 72-hour bowel and bladder tracker was completed to be assessed by licensed nursing staff to determine if a bladder and bowel retraining program was feasible or if the resident required an individualized incontinence management program to maintain skin integrity and prevent moisture associated skin damage (MASD). The facility could not provide documented evidence that Resident 34's bowel/bladder continence was assessed to develop and implement an individualized incontinence management program to deter/prevent the development of MASD. During interviews with the Director of Nursing (DON) and in the presence of the Nursing Home Administrator (NHA) on November 1, 2024, at 11:00 AM, it was revealed that Resident 34 should have been care planned for a check and change program and an every two-hour prompted toileting program. The DON and NHA confirmed there was no documented evidence that staff were consistently performing incontinence care related tasks to deter Resident 34 from developing MASD on her left buttocks. A review of Resident 19's clinical record revealed the resident was admitted to the facility on [DATE], with diagnoses that included Parkinson's disease (a brain disorder that causes unintended or uncontrollable movements, such as shaking, stiffness, and difficulty with balance and coordination), dementia, and muscle weakness. A review of the resident's initial Admission/Readmission Observation completed by the Assistant Director of Nursing (ADON) dated June 1, 2024, at 3:37 AM, indicated the resident was always incontinent of bladder and bowel. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A 72-hour toileting diary was initiated on June 1, 2023, however, the diary was not consistently completed by staff to determine a bowel and bladder pattern in order to develop an individualized continence management program in an attempt to restore normal bladder function to the extent possible for this resident which would also prevent incontinence related complications, such as skin breakdown. A review of Resident 19's admission MDS assessment dated [DATE], was coded to indicated the resident had a BIMS score (Brief Interview for Mental Status is a tool used to evaluate cognitive impairment and assist with dementia diagnosis) of 12, which indicated that the resident had moderate cognitive impairment. Additionally, the resident was dependent on staff for toileting hygiene, showering/bathing, transfers, and bed mobility. Resident 19's clinical record failed to reveal that a 72-hour bowel and bladder tracker was completed upon the resident's admission to the facility for an accurate assessment of toileting needs and/or incontinence management activities. Clinical record review revealed that Resident 20 was admitted to the facility on [DATE] with diagnosis to include, chronic kidney disease and diabetes (a group of common endocrine diseases characterized by sustained high blood sugar levels). An admission MDS dated [DATE] revealed a BIMS score of 12 (a score of 12-15 equates to intact cognition). The MDS also revealed the resident required assistance for activities of daily living and was identified to be frequently incontinent of bladder. An admission bladder assessment dated [DATE] revealed the resident had no cognitive difficulties, no history of a bladder disorder, and did not have an indwelling urinary catheter. A 72 hour bladder tracker (a documented recording of hourly urinary continence) was to be completed. A review of an evaluation for continence and retraining and scheduled toileting dated March 16, 2024 revealed that Resident 20 had mixed incontinence (symptoms of both stress incontinence, the leaking of small amounts of urine during activities that increase abdominal pressure and push down on the bladder and urge incontinence an overactive bladder, a condition that causes a sudden, strong urge to urinate that results in involuntary urine leakage) incontinence. This combination is often referred to as mixed incontinence and was the resident was placed on a bladder program. The specific program was not identified. A review of a care plan initiated March 12, 2024 for bladder incontinence revealed interventions to include, implement toileting program as indicated. This care plan did not indicate the toileting program for this resident. There were no toileting instructions for staff to provide incontinence care to this resident. This electronic care plan was initiated prior to the facility's change of electronic clinical record documentation in April 2024. It should be noted the resident's clinical documentation was not completely transferred to the new electronic charting programs. There was no current care plan in the clinical record to address the residents toileting needs at the time of the survey. There was no evidence of any additional assessments or evaluations regarding this residents bladder status at the time of the survey. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 20's clinical record failed to reveal documented evidence that a 72-hour bowel and bladder assessment was completed to be reviewed by licensed nursing staff to determine if a bladder and bowel retraining program was feasible or if the resident required an individualized incontinence management program to maintain or improve bladder function. The facility could not provide documented evidence that Resident 20's bowel/bladder continence was assessed to develop and implement an individualized incontinence management program to maintain or improve bladder function Interview with the Nursing Home Administrator on November 1, 2024, at 11:05 AM confirmed the facility failed to thoroughly assess bowel and bladder function to identify each resident's habits, patterns and plan to meet the residents' toileting needs and decrease incontinence and prevent incontinence related complications. Cross Ref. F686 28 Pa. Code 211.12 (d)(3)(5) Nursing services 28 Pa. Code 211.10 (a)(c)(d) Resident care policies.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26142 Based on clinical record review, select facility policy review and staff interview, it was determined the failed to reassess a resident's pain and repeated daily use of opioid pain medications prescribed on an as needed basis to ensure effective individualized pain management plans were developed and implemented for one of 14 residents sampled (Resident 9). Findings include: A review of a facility policy for Pain Management reviewed August 1, 2024 revealed that a pain evaluation will occur on admission/readmission to the facility, at each quarterly review, with a significant change in condition and with any onset of new pain. The evaluation will contain: - A history of pain-Presence of indicators of pain or active pain including type, intensity, characteristics, frequency -Pharmacologic and non pharmacologic interventions used in the past to address pain and the efficacy of such interventions. -The impact of pain on daily functioning, including mood, sleep and appitite -Associated symptoms -The resident's goals for pain management. The interdisciplinary team will establish a care plan to identify the resident goals identified in the assessment and the care plan will be reviewed and updated as necessary. Clinical record review revealed Resident 9 was admitted to the facility on [DATE], with diagnoses to include cerebral infarction (stroke), and pain in the right shoulder. An admission MDS (Minimum Data Set a federally mandated standardized assessment conducted at specific intervals to plan resident care) dated August 19, 2024, revealed that Resident 9 was cognitively intact with a BIMS score of 13 (a quick snapshot of cognitive function a score of 13-15 indicates cognitively intact), independent for activities of daily living and received opioid pain medications. The resident had a current physician order dated February 2, 2024, for Oxycodone 5 mg (a narcotic opioid pain medication) one tablet by mouth every 4 hours as needed for moderate to severe pain, and give one tablet by mouth every 4 hours as needed for severe pain. A review the resident's initial care plan for pain management dated October 30, 2024 revealed interventions to include, administer medications as ordered, and evaluate effectiveness of pain management program. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of narcotic medication reconciliation records and medication administration records dated February 10, 2024 through August 31, 2024 revealed staff administered the prn opioid Oxycodone 5 mg as follows, February 2024-13 doses March 2024-17 doses June 2024-13 doses July 2024-19 doses August 2024-24 doses A review of a facility form entitled Pain Interview dated March 16, 2024 revealed, that Resident 9 occasionally had moderate pain, was on a scheduled pain management regimen as well as received PRN (as needed) pain medication. There was no additional pain evaluations available to the survey team at the time of the survey. During an interview October 31, 2024 at 1 PM the Director of Nursing (DON) confirmed that Resident 9 received multiple daily doses of the prn oxycodone with no further assessment for the resident's continued daily use of the prn opioid pain medication. There was no documented evidence of additional pain relieving modalities developed and implemented to address Resident 9's pain and the development and attempts of non- pharmacological interventions to manage the resident's pain prior to the administration of the prn pain medications. There was no evidence at the time of the survey that a comprehensive evaluation of the resident's pain had been conducted in response to the resident's excessive use of the prn opioid drug to include evaluating the existing pain and the causes and developing and implementing a pain management regimen to prevent pain, consistent with the comprehensive assessment and plan of care, current professional standards of practice, and the resident's goals and preferences. 28 Pa Code 211.12 (d)(1)(3)(5) Nursing services

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39929 Based on a review of clinical records and staff interview, it was determined the facility failed to develop and implement an individualized person-centered plan to address a resident's dementia-related behavioral symptoms for two out of 12 residents (Resident 34 and 33). Findings include: A review of Resident 34's clinical record revealed that the resident was admitted to the facility on [DATE], with diagnoses that included traumatic subarachnoid hemorrhage without loss of consciousness, Alzheimer's disease (is a general term describing problems with reasoning, planning, judgment, memory and other thought processes caused by brain damage from impaired blood flow to the brain), dysphagia (difficulty swallowing), aphagia (inability to speak), and protein-calorie malnutrition. A review of the resident's current care plan, initially dated October 23, 2024, in effect at the time of the survey ending November 1, 2024, revealed no documented evidence the facility had developed an individualized person-centered plan for the resident's dementia care, while maximizing the resident's dignity, autonomy, privacy, socialization, independence, choice, and safety and using individualized, non-pharmacological approaches to care, including purposeful and meaningful activities that address the resident's customary routines, interests, preferences, and choices to enhance the resident's well-being. A review of the clinical record revealed that Resident 33 was admitted to the facility on [DATE], and had diagnoses, which included dementia (a chronic or persistent disorder of the mental processes caused by brain disease or injury and marked by memory disorders, personality changes, and impaired reasoning). A review of the resident's current care plan, initially dated September 18, 2024, in effect at the time of the survey ending November 1, 2024, revealed no documented evidence the facility had developed an individualized person-centered plan for the resident's dementia care, while maximizing the resident's dignity, autonomy, privacy, socialization, independence, choice, and safety and using individualized, non-pharmacological approaches to care, including purposeful and meaningful activities that address the resident's customary routines, interests, preferences, and choices to enhance the resident's well-being. The facility failed to develop and implement an individualized person-centered plan to address, modify and manage this resident's dementia-related behaviors. The resident's care plan for dementia failed to include individualized interventions based on an assessment of the resident's preferences, social/past life history, customary routines, and interests in an effort to manage, modify or decrease the resident's dementia-related behavioral symptoms. Interview with Nursing Home Administrator on October 31, 2024, at approximately 10:00 a.m., confirmed the facility was unable to provide evidence of the development and implementation of an individualized person-centered plan to address the resident's dementia care. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	28 Pa Code 211.12 (d)(3)(5) Nursing services

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26142 Based on review of controlled drug records and select facility policy and staff interview, it was determined the facility failed to implement pharmacy procedures for reconciling controlled drugs and records accounting for their administration for two of 14 residents sampled (Resident 9 and 90). Finding include: Clinical record review revealed Resident 9 was admitted to the facility on [DATE], with diagnoses to include cerebral infarction (stroke), and pain in the right shoulder. An admission MDS (Minimum Data Set - a federally mandated standardized assessment conducted at specific intervals to plan resident care) dated [DATE], revealed that Resident 9 was cognitively intact with a BIMS score of 13 (a quick snapshot of how well you are functioning cognitively at the moment, a score of , d+[DATE] indicates cognitively intact), independent for activities of daily living and received opioid pain medication. The resident had a current physician order dated February 2, 2024, for Oxycodone 5 mg (a narcotic opioid pain medication) one tablet by mouth every 4 hours as needed for moderate to severe pain and give one tablet by mouth every 4 hours as needed for severe pain. The resident's [DATE] individual resident controlled substance record accounting for Resident 1's supply of the controlled drug, and nursing staff's removal of doses for administration of Oxycodone 5 mg revealed that nursing staff signed out doses of the controlled medication for administration to the resident on the following dates and times: [DATE], at 1:30 AM [DATE] at 5:30 AM [DATE] at 2:00 AM A review of facility nurse staffing punch detail report for Employee 2 a licensed practical nurse(LPN), signed the above noted narcotic pain medication doses as given to the resident on the narcotic medication record. Employee 2, LPN was not on duty at the facility on the above noted dates. In addition, these doses were not signed out on the medication administration record (MAR). The resident's [DATE] individual resident controlled substance record accounting for Resident 1's supply of the controlled drug, and nursing staff's removal of doses for administration of Oxycodone 5 mg revealed that nursing staff signed out doses of the controlled drug for administration to the resident on the following dates and times: [DATE] at 1:00 AM [DATE] at 12:30 AM (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	[DATE] at 1:00 AM [DATE] at 1:30 AM A review of an [DATE] MAR, the above noted doses were not signed out on the medication administration record (MAR) as given to the resident. During an interview [DATE] at 2:00 PM, the Director of Nursing confirmed the above inconsistencies between the controlled drug records and medication administration records. A review of a facility policy for Disposal/Destruction of Expired or discontinued Medication last reviewed, [DATE] revealed, discontinued and unused medications shall be immediately removed from the medication cart and brought to the nursing supervisory staff. The facility should destroy discontinued medications. Clinical record review revealed that Resident 90 was admitted to the facility on [DATE] with diagnosis to include, hypertension, diabetes and on hospice services. A quarterly MDS dated [DATE] revealed the resident's BIM's score as 13, indicating intact cognition, required staff assistance for activities of daily living and had pain, receiving as needed pain relief medications. The resident had a physician's order dated [DATE], for Hydrocodone-Acetaminophen 7XXX,d+[DATE] mg (a narcotic, opioid and non narcotic pain medication combination) one tablet, by mouth every 6 hours as needed for severe pain rated. A Physicians order dated [DATE] revealed to discontinue the Hydrocodone-Acetaminophen 7XXX,d+[DATE] mg, one by mouth every 6 hours as needed for severe pain. The resident's individual resident controlled substance record accounting for Resident 90's supply of the controlled drug, and nursing staff's removal of doses for administration of Hydrocodone-Acetaminophen 7XXX,d+[DATE] mg revealed that Employee 2, LPN signed out doses of the controlled drug Hydrocodone-Acetaminophen 7XXX,d+[DATE] mg for administration to Resident 90 on the following dates and times after the discontinuation order from the physician: [DATE] at 5:00 AM [DATE] at 5:30 AM [DATE] at 5:30 AM [DATE] at 2:30 AM The resident's individual resident controlled substance record accounting for Resident 90's supply of the controlled drug revealed, Employee 6 an agency RN signed out a dose of the Hydrocodone-Acetaminophen 7XXX,d+[DATE] mg on [DATE] at 4:00 PM. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The above noted doses of the narcotic pain medication were documented as given on the narcotic reconciliation record, however they were not signed out as administered on the MAR. The Physician ordered narcotic pain medication order was discontinued on [DATE] and 5 doses of the medication were documented as administered as given after the medication was discontinued. During an interview on [DATE] at 1:00 PM, the Nursing Home Administrator confirmed that narcotic pain medications were not administered as per facility policy and procedure. 28 Pa Code 211.12 (d)(3)(5) Nursing services. 28 Pa Code 211.9 (a)(1)(j.1)(4)(k) Pharmacy services.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43944 Based on clinical record and staff interview, it was determined the facility failed to ensure the presence of documented evidence of clinical necessity for administration of an antibiotic drug for one resident out of 14 sampled residents. (Resident 9). Findings included: A review of Resident 9's clinical record revealed the resident was initially admitted to the facility on [DATE], with diagnoses that included osteoarthritis (a type of degenerative joint disease that results from breakdown of joint cartilage and underlying bone), muscle weakness, and recent infection of Clostridioides difficile (a highly contagious bacterium that causes diarrhea and colitis that often infects people who have recently taken antibiotics). A review of a nurse's note completed by Employee 1, a Registered Nurse (RN), dated August 10, 2024, at 2:03 PM, indicated the facility received Resident 9's initial UA (urinalysis). The primary care provider was made aware and Cefdinir (an antibiotic used to treat many different types of infections caused by bacteria) 300 mg BID (twice per day) for UTI (urinary tract infection) was ordered A review of the final C&S (culture and sensitivity- A urine culture is a method to grow and identify bacteria that may be in the urine. The sensitivity test helps select the best medicine to treat the infection) dated August 11, 2024, at 12:00 PM, revealed Cefdinir was not susceptible to the organism (bacteria) present in the urine and would not effectively treat the infection. Further review of Resident 9's clinical record revealed a progress note dated August 11, 2024, at 3:30 PM, revealed to discontinue Cefdinir and begin Levaquin (an antibiotic that is used to treat different types of bacterial infections) 500 mg daily for 7 days. Further review of Resident 9's Medication Administration Record (medication administration record, is the report that serves as a legal record of the drugs administered to a patient at a facility by a health care professional) dated August 2024, revealed the resident received four doses of Cefdinir. During an interview with the Director of Nursing on November 1, 2024, at 11:15 AM, it was confirmed the facility failed to ensure that Resident 9 received multiple doses of the antibiotic without documented evidence of its clinical necessity. 28 Pa. Code 211.2 (d)(3) Medical Director 28 Pa. Code 211.5 (f)(vii) Medical records 28 Pa. Code 211.9 (k) Pharmacy Services (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	28 Pa. Code 211.12 (d)(1)(3) Nursing Services

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43944 Based on review of clinical records and staff interview, it was determined the facility failed to maintain accurate and complete clinical records, according to professional standards of practice for two residents out of 14 sampled (Resident 34 and 19). Findings included: According to the American Nurses Association Principles for Nursing Documentation, nurses document their work and outcomes and provide an integrated, real-time method of informing the health care team about the patient status. Timely documentation of the following types of information should be made and maintained in a patient record to support the ability of the health care team to ensure informed decisions and high-quality care in the continuity of patient care: Assessments, Clinical problems, Communications with other health care professionals regarding the patient, Communication with and education of the patient, family, and the patient's designated support person and other third parties. According to the Title 49, Professional and Vocational Standards, Department of State, Chapter 21 State Board of Nursing Subsection 21.11 (a) The registered nurse assesses human responses and plans, implements and evaluates nursing care for individuals or families for whom the nurse is responsible. In carrying out this responsibility, the nurse performs all of following functions: (4) Carries out nursing care actions which promote, maintain, and restore the well-being of individuals (6)(b) The registered nurse is fully responsible for all actions as a licensed nurse and is accountable to clients for the quality of care delivered and Subsection 21.18. (a)(5) document and maintain accurate records. According to the Title 49, Professional and Vocational Standards, Department of State, Chapter 21 State Board of Nursing Subsection 21.145. (a) The licensed practical nurse (LPN) is prepared to function as a member of a health-care team by exercising sound nursing judgement based on preparation, knowledge, skills, understanding and past experiences in nursing situations. The LPN participates in the planning, implementation, and evaluation of nursing care in settings where nursing takes place. A review of Resident 34's clinical record revealed the resident was admitted to the facility on [DATE], with diagnoses that included traumatic subarachnoid hemorrhage (bleeding in the space that surrounds the brain) without loss of consciousness, Alzheimer's disease (is a general term describing problems with reasoning, planning, judgment, memory and other thought processes caused by brain damage from impaired blood flow to the brain), dysphagia (difficulty swallowing), aphasia (inability to speak), and protein-calorie malnutrition. A review of Resident 34's clinical record revealed that Employee 1, a Registered Nurse (RN), completed a wound observation entry note for the re-opening of MASD (moisture associated skin damage - refers to inflammation or skin erosion caused by prolonged exposure to moisture from sources such as urine, stool, sweat, wound drainage, saliva, or mucus) dated July 16, 2024, at 12:59 PM, but identified on July 15, 2024, at 6:58 PM, that measured 2.0 centimeters (cm) in length by 2.0 cm in width. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	396095	A. Building B. Wing	11/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Scranton Health Care Center	2933 McCarthy Street Scranton, PA 18505

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility could not provide documented evidence that preventative measures were in place and completed to deter or prevent a re-opening of the MASD to Resident 34's left buttocks. Further review of Resident 34's clinical record revealed that Employee 1,RN completed a wound observation entry for a pressure ulcer to the sacrum (a triangular bone at the base of the spinal column that connects with or forms a part of the pelvis) dated July 24, 2024, at 7:21 AM, but identified on July 23, 2024, at 9:15 AM. Employee 1 noted the area measured 2.8 cm in length by 2.5 cm in width with no depth measured, no exudate, and no odor. The area was identified as unstageable (deep tissue, no undermining, margins of sacrum were discolored and non-blanchable, and skin surrounding wound color was dark purple or rusty discoloration). A review of a wound observation completed by Employee 1 RN and dated August 1, 2024, at 9:12 AM, revealed the unstageable/deep tissue area to the sacrum was assessed on July 31, 2024 the area was opened and now a Stage 3 pressure ulcer (have gone through the second layer of skin into the fat tissue with symptoms that include a crater appearance, may have a foul odor, and may show signs of infection such as red edges, pus, odor, heat, and/or drainage with the tissue in or around the sore appearing black indicating dead tissue) measured 2.0 cm in length by 1.5 cm in width with 0.2 cm in depth with a light amount of serosanguineous (pale red to pink, thin and watery) exudate, no odor, with 75-percent granulation tissue covering the wound, and 24-percent of the wound covered with slough (dead tissue) with the edges attached to base of the wound. The wound observation indicated that preventative measures were in place such as a low loss air mattress, turning and repositioning, bilateral heel bows, and barrier cream, and the use of a Broda chair with pressure reducing cushion. However, the facility could not provide documented evidence that preventative measures such as turning and repositioning and barrier cream were implemented and completed by staff to prevent the development of MASD and pressure ulcers. Additionally, the resident's comprehensive person-centered plan of care failed to specify individualized interventions to prevent the development of skin impairments such as MASD and pressure ulcer. During interviews with the Director of Nursing (DON) and in the presence of the Nursing Home Administrator (NHA) on November 1, 2024, at 10:36 AM, it was revealed that some of Resident 34's preventative measures for pressure ulcer/skin preventions such as turning and repositioning, checking and changing the resident, and skin prep post incontinent episodes to prevent skin impairments were not carried over from the previous EHR (electronic health record system) to the newly implemented EHR that was implemented mid May 2024. The DON reported that Resident 34's plan of care did not accurately reflect the actual care and services provided to the resident in efforts to maintain skin integrity. Additionally, it was confirmed the facility failed to assure that Resident 34's clinical record accurately reflected the resident's individual care needs and assure documentation was recorded by staff to indicate care and services provided to prevent the development of skin impairments. A review of Resident 19's clinical record revealed the resident was admitted to the facility on [DATE], with diagnoses that included Parkinson's disease (a brain disorder that causes unintended or uncontrollable movements, such as shaking, stiffness, and difficulty with balance and coordination), dementia, and muscle weakness. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A 72-hour toileting diary was initiated on June 1, 2023; however, the diary was not consistently completed by staff to determine a bowel and bladder pattern to develop an individualized continence management program for the resident to maintain or improve her continence. Resident 19's clinical record failed to reveal that a 72-hour bowel and bladder tracker was completed upon the resident's admission to the facility for an accurate assessment of toileting needs and/or incontinence management activities. During an interview with the DON and NHA on November 1, 2024, at 10:45 AM, revealed that Resident 19's 72-hour bowel and bladder tracker required to assess and develop an individualized incontinence management program to meet her individual needs, was not consistently completed by staff in order to maintain or improve the resident's incontinence by determined a toileting plan after completion of the bowel and bladder tracking tool. 28 Pa. Code 211.5 (f)(iii) Medical records. 28 Pa. Code 211.12 (c)(d)(1)(5) Nursing services.