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	08/21/2025

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow resident to participate in the development and implementation of his or her person-centered plan of care. (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 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility policy review, observations, and staff and resident interviews, it was determined the facility failed to honor and incorporate the resident's expressed preferences and choices into the care planning process for one of 14 sampled residents (Resident 2).Findings include:A review of Resident 2's clinical record revealed Resident 2 was admitted to the facility February 28, 2025, with diagnoses to include alcoholic cirrhosis of liver (liver becomes damaged and can no longer process the fat cells that typically turn into energy, nutrients, and waste) with ascites (accumulation of fluid causing abdominal swelling). A review of a Resident 2's quarterly Minimum Data Set Assessment (MDS-a federally mandated standardized assessment conducted at specific intervals to plan resident care), dated July 11, 2025, revealed Resident 2 was cognitively intact with a BIMS score of 14 (brief interview for mental status, a tool to assess the residents attention, orientation and ability to register and recall new information, a score of 13-15 indicates intact cognition). A review of the comprehensive care planning policy last reviewed by the facility on July 22, 2025, revealed that the facility will develop a comprehensive person-centered care plan for each resident. The policy further described the plan will be focused on resident choices and abilities with the intent of maintaining or improving resident functional abilities and quality of life. Review of a physician's order dated June 6, 2025, documented Prevalon boots (a cushioned, air-filled boot which fits to the natural shape of the foot to promote circulation and pressure redistribution) to be worn while in/out of bed. Also, the boots may be removed for hygiene and skin checks. A clinical record review of Resident 2's comprehensive care plan, in effect through the survey end date of August 21, 2025, revealed Resident 2 experiences a self-care deficit related to impaired mobility and generalized weakness. The care plan further revealed that a goal for Resident 2 will not deteriorate in ADL (activities of daily living) functional status. Nursing progress notes dated June 5, 2025, documented the initiation of the Prevalon boots for preventive care. Additional nursing documentation from June through August 2025 indicated the resident frequently refused to wear the boots and was re-educated on their purpose to prevent foot drop (the inability to lift the front part of the foot due to muscle weakness or nerve damage).A review of the Treatment Administration Record (TAR) for June through August 2025 confirmed multiple documented refusals by the resident to wear the boots. Observation of Resident 2 on August 19, 2025, and August 20, 2025, at approximately 10:00 AM revealed Resident 2 lying in bed, feet exposed, heels elevated off a pillow. At the time of both observations, [NAME] boots were not in place. Interview with Resident 2 on August 20,2025 at approximately 10:00 AM confirmed the resident preferred not to wear the boots. A clinical record review revealed multiple instances of nursing progress note documentation and Treatment Administration Record (TAR) documentation of Resident 2's choice to not wear the Prevalon boots. An interview with the Nursing Home Administrator on August 20, 2025, at 1:30 PM confirmed the resident's expressed choice regarding the refusal of the Prevalon boots was not documented or addressed in the resident's care plan. 28 Pa. Code 201.29 (a) Resident rights. 28 Pa. Code 211.10 (c)(d) Resident care policies. 28 Pa. Code 211.12(d)(3) Nursing services.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the Resident Assessment Instrument (RAI) Manual, a review of clinical records, resident observation, and staff interviews, it was determined that the facility failed to complete an accurate Minimum Data Set (MDS, a federally mandated standardized assessment conducted at specific intervals to plan resident care) for one of 14 residents sampled (Resident 38). Findings include:The Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual, which provides instructions and guidelines for completing the Minimum Data Set (MDS a federally mandated standardized assessment conducted at specific intervals to plan resident care) dated October 2024, requires the assessment accurately reflects the resident's status, a registered nurse conducts or coordinates each assessment with the appropriate participation of health professionals, and the assessment process includes direct observation, as well as communication with the resident and direct care staff on all shifts. A clinical records review revealed Resident 38 was admitted to the facility on [DATE], with diagnoses to include dementia (decline in cognitive function affecting memory, language, and thinking) and rheumatoid arthritis (a chronic autoimmune disease where the body's immune system mistakenly attacks its own tissues, primarily the joints). A quarterly MDS, section GG-0115 (section related to functional abilities- the ability to perform tasks and activities necessary for daily living) dated August 6, 2025, revealed Resident 38 experienced no impairment in range of motion (referring to the full movement of a joint or series of joints, measured in degrees) for upper and lower extremities. Observation of Resident 38 on August 19, 2025, at approximately 11:00 AM revealed the resident's lower extremities to be in a flexed (knee joint is bent bringing foot closer to thigh) position while seated in a chair. Further observation revealed Resident 38's right hand to be in a closed position. Employee 1 Nurse Aide (NA) reported Resident 38 could not independently open her right hand and required staff assistance with movement of the right hand (including wrist and fingers). An observation conducted on August 21, 2025, at approximately 09:00 AM revealed Resident 38 to be using her right hand to feed herself. Further observation of Resident 38 in the therapy room on August 21, 2025, at 9:50 AM in the presence of Employee 2 (Occupational Therapist), Employee 3 (Physical therapist) and the Nursing Home Administrator (NHA) revealed Resident 38's lower extremities in a straight position while seated. Employee 3 (Physical therapist) confirmed Resident 38 has full range of motion in the lower extremities. Further observation of Resident 38 noted the resident was able to open the right hand with assistance of the NHA. Resident 38 was observed to have limited range of motion in the right wrist. Employee 2 (Occupational Therapist) confirmed that Resident 38 has limited range of motion in her right wrist due to an underlying condition. A clinical record review dated September 7, 2024, revealed a right wrist X-ray confirming osteoarthritis (occurs when the cartilage that lines the joints is worn down and the bones rub together when the joint is used). Interview with the NHA revealed the quarterly MDS did not accurately reflect the resident's limited range of motion. Review of the RAI manual describes coding for Section GG0120C, the section which addresses mobility. The instructions on coding wheelchair mobility apply to wheelchairs that are hand propelled, motorized, or pushed by another person. The RAI manual further describes Section GG0120C should not include geriatric-chairs, reclining chairs with wheels, positioning chairs, scooters, or other types of specialty chairs. A review of Resident 38's Quarterly MDS dated [DATE], section GG-0120, revealed Resident 38 utilized a manual wheelchair and is dependent on chair mobility. Observation conducted on August 20, 2025, at approximately 12:00 PM revealed Resident 38 to be sitting in a reclining, cushioned chair with a blue overlay (one surface is placed over another surface). Interview with Employee 2 (Occupational Therapist), on August 20, 2025, at 12:15 PM confirmed Resident 38 utilizes a Broda chair (chair used for comfort, support, and mobility). Review of Resident 38's clinical record revealed a physical therapy note dated on August 13, 2025, documenting the use of a Broda chair Interview with Employee 4 (via telephone) Regional Reimbursement Specialist (LPN licensed practical nurse) conducted on August 20, 2025, at 11:41 AM, and could not confirm the MDS was coded accurately. A review of the above information was conducted with the Director of Nursing and NHA on August 21, 2025, at approximately 11:00 AM. The facility was unable to produce documentation to support incorrect MDS coding for Resident 38. 28 Pa. Code 211.5(f)(iii) Medical records28 Pa. Code 211.12(d)(1)(5) Nursing services

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of clinical records, select facility policy and staff interviews it was determined the facility failed to develop and implement individualized pain management programs, consistent with professional standards of practice, to meet the pain management needs and attempt non-pharmacological interventions to alleviate pain prior to the administration of a narcotic pain medication prescribed on an as needed basis for one resident out of 14 residents reviewed (Resident 6). Findings include: According to the US Department of Health and Human Services, Interagency Task Force, Executive Summary Draft Final Report May 6, 2021, for Pain Management Best Practices the development of an effective pain treatment plan after proper evaluation to establish a diagnosis with measurable outcomes that focus on improvements including quality of life (QOL), improved functionality, and Activities of Daily Living (ADLs). Achieving excellence in acute and chronic pain care depends on the following: An emphasis on an individualized patient-centered approach for diagnosis and treatment of pain is essential to establishing a therapeutic alliance between patient and clinician. Acute pain can be caused by a variety of different conditions such as trauma, burn, musculoskeletal injury, neural injury, as well as pain due to surgery/procedures in the perioperative period. A multi-modal approach that includes medications, nerve blocks, physical therapy and other modalities should be considered for acute pain conditions. A multidisciplinary approach for chronic pain across various disciplines, utilizing one or more treatment modalities, is encouraged when clinically indicated to improve outcomes. A review of a facility policy last reviewed by the facility on July 22, 2025, revealed the physician will order appropriate non-pharmacologic and medication interventions to address a resident's pain. The policy further revealed non-pharmacological interventions will be attempted prior to the administration of PRN (as needed) pain medications. If the non-pharmacological interventions fail the resident will be administered the PRN narcotic medication. A review of Resident 6's clinical record revealed the resident was admitted to the facility on [DATE], with diagnoses, which included Fracture of upper and lower end of left fibula, and muscle weakness.A review of a physician order initially dated May 21, 2025, revealed the resident was ordered Oxycodone (a narcotic pain medication) 5mg, give 1 tablet by mouth every 4 hours as needed for pain. A review of the resident's May 2025 Medication Administration Record (MAR) revealed staff administered the as needed (PRN). Oxycodone 9 times. Of the nine doses given, 9 doses were administered with no non-pharmacological interventions attempted prior to giving the pain medication, despite the policy indicating the need for the non-pharmacological interventions prior to administering the medication. A review of the resident's June 2025 MAR revealed staff administered the as needed (PRN) Oxycodone 23 times. Of the twenty-three doses given, 23 doses were administered with no non-pharmacological interventions attempted prior to giving the pain medication, despite the facility policy. A review of the resident's July 2025 MAR revealed staff administered the as needed (PRN) Oxycodone 34 times with no non-pharmacological interventions attempted prior to giving the pain medication, despite the facility policy. A review of the resident's August 2025 MAR revealed staff administered the as needed (PRN) Oxycodone 11 times. Of the eleven doses given, 10 doses were administered with no non-pharmacological interventions attempted prior to giving the pain medication, despite the order indicating the need for the non-pharmacological interventions. An interview with the Nursing Home Administrator on August 20, 2025, at approximately 1:00PM revealed the facility was unable to supply supporting documentation that nonpharmacological interventions were attempted prior to the administration of the as needed pain medication for resident 6. 28 Pa. Code 211.12 (d)(1)(3)(5) Nursing services 28 Pa. Code 211.10(c) Resident care policies