| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 396095 | A. Building<br>B. Wing | 06/18/2026 |

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

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>Based on observation, review of select facility policy, and staff interview, it was determined the facility failed to maintain acceptable practices for the storage and service of food to prevent the potential for contamination and microbial growth in food, which increased the risk of food-borne illness in the food and nutrition services department. Findings include: Food safety and inspection standards for safe food handling indicate that everything that comes in contact with food must be kept clean, and food that is mishandled can lead to foodborne illness. Safe steps in food handling, cooking, and storage are essential in preventing foodborne illness. You cannot always see, smell, or taste harmful bacteria that may cause illness, according to the USDA (the United States Department of Agriculture, also known as the Agriculture Department, is the U.S. federal executive department responsible for developing and executing federal laws related to food). A review of a facility policy titled Kitchen Sanitation and Cleaning Schedules Policy, last reviewed by the facility on May 26, 2026, revealed it is the facility policy that food and nutrition services staff will maintain the sanitation of the kitchen through compliance with a written, comprehensive cleaning schedule. During the initial kitchen tour on June 16, 2026, at 8:20 AM, accompanied by the Dietary Manager, the following unsanitary practices with the potential to introduce contaminants into food and increase the potential for food-borne illness were observed: The ice machine condensation drainpipe, which removes excess water from the ice machine, drained without an air gap (the unobstructed vertical space between the end of a drainpipe and the receiving drain. This separation prevents contaminated wastewater from flowing backward into the ice machine where ice intended for resident consumption is produced. Without an air gap, contaminated water can backflow into the machine, increasing the risk that harmful bacteria or other contaminants could enter the ice). A black substance was present on the end of the ice machine condensation drainpipe. The accumulation of residue on equipment associated with food production has the potential to harbor microorganisms that may contaminate food or ice. Pans were present in the kitchen's three-compartment sink. Observation of the facility's sanitizer test strips revealed they were dated October 3, 2023, and had expired in April 2025. Sanitizer test strips are used to verify that the concentration of sanitizing chemicals is strong enough to destroy harmful bacteria but not so concentrated that chemical residue remains on food-contact surfaces. Without valid test strips, staff cannot verify that dishes, utensils, and equipment are being sanitized effectively. During an interview on June 16, 2026, at 8:20 AM, the Dietary Manager confirmed the sanitizer test strips had expired and acknowledged that no replacement test strips were available in the facility to verify the concentration of sanitizer used in the three-compartment sink. The Dietary Manager further confirmed that kitchen equipment is sanitized, allowed to air dry, and then stored for future food preparation and service. During an interview on June 18, 2026, at 9:00 AM, the above information was reviewed with the Nursing Home Administrator. The facility failed to maintain acceptable practices for the storage and service of food to prevent the potential for contamination and microbial growth in food, which increased the risk of food-borne illness in the food and nutrition services department. 28 Pa. Code 201.18 (e) (2.1) Management. |

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 0641<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure each resident receives an accurate assessment.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of clinical records, Resident Assessment Instrument (RAI) assessments, the RAI User's Manual, and staff interviews, it was determined the facility failed to ensure Minimum Data Set (MDS) assessments were completed accurately and within required federal timeframes for two of 15 residents reviewed (Residents 23 and 28). The facility failed to complete a required OBRA Discharge Assessment within the required timeframe and accurately document the resident's discharge information for one resident (Resident 23) and failed to ensure the MDS accurately reflected a resident's Level II Preadmission Screening and Resident Review (PASRR), status for one resident (Resident 28).Findings include: The Long Term Care Facility RAI User's Manual, which provides instructions and guidelines for completing the Minimum Data Set (MDS, a federally required standardized assessment used to evaluate a resident's physical, psychological, and psychosocial status and to develop an individualized plan of care) dated October 2025, requires the assessment to accurately reflect the resident's status. The manual requires a registered nurse to conduct and coordinate each assessment with the appropriate participation of health professionals; the assessment process includes direct observation as well as communication with the resident and direct care staff on all shifts. A clinical record review revealed Resident 23 was admitted to the facility on [DATE], with diagnoses that included diabetes (a chronic disease that occurs either when the pancreas does not produce enough insulin or when the body cannot effectively use the insulin it produces) and anxiety disorder (a condition in which excessive worry causes clinically significant distress or impairment in social, occupational, or other areas of functioning). A review of the clinical record of Resident 23's BIMS score (Brief Interview for Mental Status, a tool to assess the residents' attention, orientation, and ability to register and recall new information; a score of 0 through 7 indicates severe cognitive impairment), dated June 15, 2026, revealed the resident was severely cognitively impaired with a BIMS score of 00. According to the RAI manual, an OBRA Discharge Assessment-Return Anticipated (item A0310F) must be completed when the resident is discharged from the facility and the resident is expected to return to the facility within 30 days. For a resident discharged to a hospital or other setting who comes in and out of the facility on a relatively frequent basis and reentry can be expected, the resident is discharged with return anticipated unless it is known on discharge that they will not return within 30 days. This status requires an entry tracking record each time the resident returns to the facility and an OBRA discharge assessment each time the resident is discharged and must be completed (item Z0500B) within 14 days after the discharge date (item A2000). A review of Resident 23's clinical record during the survey revealed the resident was discharged to the hospital on May 9, 2026, with an anticipated return. However, the required OBRA Discharge Assessment contained an incorrect discharge date of April 9, 2026, rather than the actual discharge date of May 9, 2026. Review further revealed the assessment remained incomplete and was identified as late, exceeding the required 14-day completion timeframe. During an interview on June 17, 2026, at 12:10 PM, Employee 3, Licensed Practical Nurse, acknowledged the discharge date entered on the assessment was incorrect, confirmed the resident was discharged on May 9, 2026, and acknowledged the required assessment was not completed within the federally required timeframe. A clinical record review revealed Resident 28 was admitted to the facility on [DATE], with diagnoses that included major depressive disorder (a mental health disorder characterized by a persistently low or depressed mood, decreased interest in pleasurable activities, feelings of worthlessness, lack of energy, poor concentration, appetite changes, sleep disturbances, or suicidal thoughts) and anxiety disorder. A review of Resident 28's quarterly MDS, dated [DATE], revealed that Resident 28 was cognitively intact with a BIMS score of 13 (a score of 13 through 15 indicates cognition is intact). A review of Resident 28's annual MDS assessment dated [DATE], Section A 1500 Preadmission Screening and Resident Review (PASRR, a required federal screening to ensure residents receive<br>(continued on next page) |

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| F 0641<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | care in the most appropriate, least restrictive setting and get needed specialized services, rather than being placed inappropriately in a nursing home) revealed the resident was not currently considered by the state level II PASRR (a level II PASRR indicates the resident has been identified through the state mental health authority as having a serious mental health diagnosis and qualifies for additional services to meet the resident's needs) process to have serious mental illness, intellectual disability or a related condition. However, review of the clinical record revealed a determination letter dated August 21, 2024, from the Pennsylvania Department of Human Services, Office of Mental Health and Substance Abuse Services, (OMHSAS) documented that Resident 28 met the criteria for review by the state mental health authority, was determined appropriate for nursing facility placement, and required the facility to provide or arrange specialized mental health services. Therefore, Resident 28 met the criteria for a Level II PASRR determination. During an interview with Employee 3, Licensed Practical Nurse, on June 17, 2026, at 12:10 PM, confirmed that Resident 28 had a serious mental health diagnosis and had a Level II PASRR determination and acknowledged Section A1500 of the annual MDS dated [DATE], was not coded accurately. During an interview on June 17, 2026, at 2:30 PM, the findings were reviewed with the Director of Nursing (DON). The facility failed to complete the required MDS assessment within the required timeframe for Resident 23 and failed to ensure the MDS accurately reflected Resident 28's PASRR Level II status. 28 Pa. Code 211.5(f)(iv) Medical records. 28 Pa. Code 211.12(c)(d)(1)(5) Nursing services. 28 Pa. Code 201.18(e)(1) Management. |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure services provided by the nursing facility meet professional standards of quality.<br><br>Based on observation, review of clinical records, review of facility policy, and staff interview, it was determined the facility failed to provide care and services consistently with accepted professional standards of nursing practice by failing to implement a physician-ordered bowel management protocol and notify the practitioner as directed for one of 15 residents reviewed (Resident 7). Findings include: According to the American Academy of Family Physicians (one of the largest medical organizations in the US founded to promote the science and art of family medicine) the primary goal of constipation management is improvement of symptoms and the regular passage of soft, formed stools without straining at least three times per week. A review of Resident 7's clinical record revealed physician orders dated December 30, 2025, for a bowel management protocol to be initiated after 48 hours without a bowel movement, consisting of: Step 1: Administer MiraLAX (polyethylene glycol 3350, a medication that draws water into the bowel to soften stool) 17 grams mixed in 4 to 8 ounces of liquid. Step 2: If no bowel movement occurred by 10:00 AM the following day, repeat MiraLAX 17 grams. Step 3: If no bowel movement occurred by the following morning, administer an Enemeez Micro Enema (a small-volume rectal enema used to stimulate a bowel movement). If no bowel movement occurred within one hour, notify the provider. A review of Resident 7's bowel tracking record for January 2026 revealed no documented bowel movement during all three shifts on January 16, 17, 18, 20, 21, 22, and 23, 2026. A review of the January 2026 Medication Administration Record revealed no documented evidence that nursing staff implemented the physician-ordered bowel protocol during these periods of absent bowel movements. Record review revealed that an Enemeez Micro Enema 5 ml was administered on January 17, 2026, at 6:12 AM. The bowel tracking record contained no documented evidence that the resident had a bowel movement following administration of the enema. Additionally, there was no documented evidence that the physician was notified within one hour when the enema failed to produce a bowel movement, as required by the physician's order. During an interview on June 17, 2026, at 2:00 PM, the Director of Nursing reviewed the above findings and was unable to provide evidence that nursing staff implemented the physician-ordered bowel protocol or notified the provider as ordered during the periods in which Resident 7 had no documented bowel movement. 28 Pa. Code 211.5(f)(v111)(ix)Medical records 28 Pa Code 211.10 Resident care policies. 28 Pa. Code 211.12 (d)(1)(3)(5) Nursing services. |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate pressure ulcer care and prevent new ulcers from developing.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, a review of clinical records, the alternating air mattress manufacturer's instructions, select facility policies, and staff interviews, it was determined the facility failed to consistently implement physician-ordered and care-planned interventions to prevent the development of pressure injuries for one of 15 residents reviewed (Resident 14). Findings include: According to the National Library of Medicine, pressure ulcers develop when capillaries supplying the skin and tissues are compressed enough to impede circulation, leading ultimately to tissue death. Normal blood pressure within capillaries ranges from 20 to 40 mmHg (millimeters of mercury is a standard unit of measurement for pressure; it is used to measure blood pressure by expressing how hard the blood pushes against the walls of the arteries). Keeping the external pressure less than 32 mmHg should be sufficient to prevent the development of pressure ulcers. However, capillary blood pressure may be less than 32 mmHg in critically ill patients; thus, even lower applied pressures may be sufficient to induce ulceration in this group of patients. Prolonged pressure over bony prominences can exceed capillary closing pressure (32 mmHg) and lead to cell death and ultimately ulcer formation. A review of the manufacturer's instructions for the alternating air mattress revealed the caregiver is to adjust the mattress pressure by selecting the resident's corresponding weight using the weight setting controls. The mattress pressure is designed to be adjusted according to the resident's body weight and desired firmness, so the support surface functions as intended to redistribute pressure. Failure to use the appropriate weight setting may reduce the mattress's ability to provide effective pressure redistribution and increase the risk for pressure-related skin injury. A clinical record review revealed Resident 14 was admitted to the facility on [DATE], with diagnoses that include peripheral vascular disease (a condition in which narrowed arteries reduce blood flow to the arms or most commonly to the legs). A care plan initiated on May 20, 2026, identified Resident 14 as being at risk for skin injury. Interventions included using pressure-relieving devices for both the wheelchair and mattress to maintain skin integrity. A care plan initiated on May 27, 2026, identified venous and arterial ulcers (wounds caused by impaired blood circulation through the veins and arteries) involving the left heel, left calf, and right shin. Interventions directed staff to use pressure-reducing devices while the resident was in bed to promote healing without complications. A physician's order initiated on May 15, 2026, directed staff to provide an alternating pressure mattress and check the mattress settings every shift. A nursing progress note dated June 10, 2026, at 11:22 AM documented Resident 14's weight as 202.7 pounds. Observation on June 16, 2026, at 10:34 AM revealed Resident 14 lying in bed on an alternating air mattress. The mattress weight setting remained adjusted to the maximum 450-pound setting rather than the resident's documented weight. Observation on June 17, 2026, at 1:57 PM again revealed Resident 14 lying in bed with the alternating air mattress remaining at the maximum 450-pound setting. During an interview on June 17, 2026, at 2:00 PM, Employee 4, Registered Nurse, confirmed the alternating air mattress should be adjusted to correspond with the resident's weight. A wound care note dated June 17, 2026, documented Resident 14 had bilateral dermatoses (skin disorders affecting both lower extremities) and a new open area on the left buttock measuring 1.0 centimeters by 1.0 centimeters by 0.2 centimeters. The wound bed consisted of 50 percent epithelial tissue (new skin forming during healing) and 50 percent granulation tissue (healthy red tissue that develops as a wound heals). A small amount of serosanguineous drainage (thin pink or blood-tinged fluid) was present. The wound care provider identified Resident 14 as being at high risk for pressure injury development and recommended continuing turning and repositioning, use of an alternating low air loss mattress for pressure redistribution and ensuring the air mattress settings were appropriate for the resident's weight. The clinical record contained no physician order, nursing assessment, wound care documentation, or other clinical justification supporting the continued use of the maximum 450-pound mattress setting for a resident whose documented weight was 202.7 pounds.<br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on June 18, 2026, at 9:00 AM, the above information was reviewed with the Nursing Home Administrator. The facility failed to consistently implement physician-ordered and care-planned pressure-relieving interventions by failing to ensure the alternating air mattress was adjusted based upon the resident's assessed needs, documented weight, manufacturer's operating instructions, and wound care recommendations. The facility also failed to demonstrate a documented clinical basis for maintaining the mattress at the maximum setting, reducing assurance that the pressure redistribution surface was being used as intended to help prevent pressure injury development. 28 Pa. Code 201.18(b)(1) Management 28 Pa. Code 211.10(c)(d) Resident care policies. 28 Pa. Code 211.12(c)(d)(1)(3)(5) Nursing services. |