STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395067	A. BLDG: 00 B. WING:	01/31/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
GREEN RIDGE CARE CENTER STATE LICENSE NUMBER: **332302**	**2741 BOULEVARD AVENUE** **SCRANTON, PA 18509**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0000	INITIAL COMMENT Based on a Medicare/Medicaid Recertification, State Licensure, and Civil Rights Compliance survey completed on January 31, 2025, it was determined that Green Ridge Care Center was not in compliance with the following requirements of 42 CFR Part 483 Subpart B Requirements for Long Term Care Facilities and the 28 PA Code Commonwealth of Pennsylvania Long Term Care Licensure Regulations.	F 0000		
F 0660 SS=D		F 0660		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: | (X6) DATE:

Any deficiency statement ending with an asterisk (*) denotes a deficiency which may be excused from correction providing it is determined that other safeguards provide sufficient protection to the patients. The findings stated above are disclosable whether or not a plan of correction is provided. The findings are disclosable within 14 days after such information is made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

This form is a printed electronic version of the CMS 2567L. It contains all the information found on the standard document in much the same form. This electronic form once printed and signed by the facility administrator and appropriately posted will satisfy the CMS requirement to post survey information found on the CMS 2567L.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0660 SS=D	Continued from page 1 483.21(c)(1)(i)-(ix) Discharge Planning Process §483.21(c)(1) Discharge Planning Process The facility must develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. The facility's discharge planning process must be consistent with the discharge rights set forth at 483.15(b) as applicable and- (i) Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident. (ii) Include regular re-evaluation of residents to identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes. (iii) Involve the interdisciplinary team, as defined by §483.21(b)(2)(ii), in the ongoing process of developing the discharge plan. (iv) Consider caregiver/support person availability and the resident's or caregiver's/support person(s) capacity and capability to perform required care, as part of the identification of discharge needs. (v) Involve the resident and resident representative in the development of the discharge plan and inform the resident and resident representative of the final plan. (vi) Address the resident's goals of care and treatment preferences.	F 0660	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. This statement applies to all observations listed below. Resident 3 had their discharge plan revised, to reflect the resident's current desire for discharge. To identify other residents that have the potential to be affected, the Social Service Director / designee will review the short-term residents in-house to assure that an individualized discharge plan reflects the residents' current desire for discharge or long-term placement. To prevent this from re-occurring, Social Services will be re-educated to follow up on documentation noted in the medical record of a resident	Completion Date: **02/25/2025** Status: **APPROVED** Date: **02/13/2025**

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F 0660 SS=D	Continued from page 2 (vii) Document that a resident has been asked about their interest in receiving information regarding returning to the community. (A) If the resident indicates an interest in returning to the community, the facility must document any referrals to local contact agencies or other appropriate entities made for this purpose. (B) Facilities must update a resident's comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities. (C) If discharge to the community is determined to not be feasible, the facility must document who made the determination and why. (viii) For residents who are transferred to another SNF or who are discharged to a HHA, IRF, or LTCH, assist residents and their resident representatives in selecting a post-acute care provider by using data that includes, but is not limited to SNF, HHA, IRF, or LTCH standardized patient assessment data, data on quality measures, and data on resource use to the extent the data is available. The facility must ensure that the post-acute care standardized patient assessment data, data on quality measures, and data on resource use is relevant and applicable to the resident's goals of care and treatment preferences. (ix) Document, complete on a timely basis based on the resident's needs, and include in the clinical record, the evaluation of the resident's discharge needs and discharge plan. The results of the evaluation must be discussed with the resident or resident's representative. All relevant	F 0660	change related discharge planning to discharge home or remain long-term and the care plan will be updated to reflect the residents' wishes. To monitor and maintain compliance, the Social Service Director / designee will randomly review social service notes each week of five short term residents for documentation related to discharge planning and check that the care plan on discharge reflects the residents' current discharge plan as documented in the clinical notes. The audits will be completed weekly times 4 weeks and then monthly times 2. The results of the audits will be forwarded to QAPI committee for further review and recommendations.	

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F 0660 SS=D	Continued from page 3 resident information must be incorporated into the discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident's discharge or transfer. This REQUIREMENT is not met as evidenced by:	F 0660		

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F 0660 SS=D	Continued from page 4 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 19 residents reviewed (Resident 3) to reflect the resident's discharge goals. Findings Include: Clinical record review revealed that Resident 3 was admitted to the facility on November 8, 2023, with diagnoses to include atrial fibrillation (an irregular and often very rapid heart rhythm). Review of a quarterly Minimum Data Set Assessment (MDS- a federally mandated standardized assessment process completed at specific intervals to plan resident care) dated January 15, 2025, indicated the resident had a BIMS (brief interview mental screener that aids in detecting cognitive impairment) score of 15 indicating she was cognitively intact. A review of Resident 3's social service notes,	F 0660		

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F 0660 SS=D	Continued from page 5 revealed a note dated August 28, 2024, indicating the resident would like to be discharged home when able. The next social service notes regarding discharge from the facility were not until November 18, 2024, indicating the resident was to be discharged home on December 13, 2024. During the survery ending January 31, 2025 there was no further documentation regarding discharge to home and no documentation regarding the reason the resident did not discharge home on December 13, 2024. A review of the resident's comprehensive care plan, reviewed during the survey ending January 31, 2025, revealed no documented evidence that an individualized discharge plan was revised, as needed to reflect the resident's current desire for discharge or long-term placement at the facility. During an interview with the Nursing Home Administrator on January 30, 2025, at 12:00 PM confirmed there was no documented evidence of a current discharge goal and plan for this resident.	F 0660		

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F 0660 SS=D	Continued from page 6 28 Pa. Code 201.18(b)(1) Management 28 Pa. Code 201.29 (a) Resident rights.	F 0660		
F 0697 SS=E		F 0697		

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F 0697 SS=E	Continued from page 7 483.25(k) Pain Management §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by:	F 0697	The DON / designee will complete a pain observation for R18. A review for R18's current pain medication and alternative pain management strategies will be completed to determine if the current orders address the current pain severity and that there are alternative pain management strategies in place to offer before resorting to medication. To identify other residents that have the potential to be affected, the DON / designee will complete an audit for current residents taking PRN pain medications to verify if medications are being given as ordered per the pain severity listed and alternative pain management strategies were offered before resorting to medication. Follow up will occur based on the results of the audit. To prevent this from reoccurring, the DON / designee will educate licensed nurses on the Pain Management Policy including administering medications based on severity of the pain and offering /	Completion Date: **02/25/2025** Status: **APPROVED** Date: **02/13/2025**

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F 0697 SS=E	Continued from page 8	F 0697	documenting alternative pain management strategies before resorting to medication. To monitor and maintain compliance, the DON / designee will audit 10 residents' records who have received PRN pain medication to ensure that alternative pain management strategies were attempted before resorting to medication and if a medication was administered it was given per the resident's pain severity, as ordered by the physician. The audits will be completed weekly times 4 weeks and then monthly times 3. The results of the audits will be forwarded to QAPI committee for further review and recommendations.	

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F 0697 SS=E	Continued from page 9 Based on clinical record review, facility policy review, and staff interviews, the facility failed to provide effective pain management, administer pain medication as prescribed by the physician, and attempt non-pharmacological interventions prior to administering narcotic pain medication prescribed on an as-needed (PRN) basis for one (1) of three (3) residents sampled for pain (Resident 18). Findings include: A review of the facility's policy titled "Pain Management", with a policy review date of December 2024, indicated that an evaluation of pain presence and severity should occur using the appropriate pain scale (numeric pain rating scale, face rating scale, or verbal descriptor scale). The policy further stated that non-pharmacological interventions will be attempted prior to the administration of PRN (as needed) pain medications. If non-pharmacological interventions are ineffective, then when multiple PRN medications are available with corresponding intensity ratings, the	F 0697		

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F 0697 SS=E	Continued from page 10 resident will receive the medication prescribed for the corresponding pain rating. Documentation of medication administration and effectiveness is required in the electronic medication record (eMAR). A review of the clinical record revealed that Resident 18 was admitted to the facility on December 30, 2024, with diagnoses to include fibromyalgia (is a disorder that affects muscle and soft tissue characterized by chronic muscle pain, tenderness, fatigue and sleep disturbances), rheumatoid arthritis (a chronic inflammatory disorder affecting small joints in the hands and feet characterized by painful swelling in the affected areas) and complete rotator cuff tear of the right shoulder (a complete tear of the connecting muscle to bone of the shoulder, characterized by pain of the affected shoulder). A review of Resident 18's physician orders revealed the following PRN pain medication orders:	F 0697		

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F 0697 SS=E	Continued from page 11 Percocet 5/325mg (narcotic pain medication) one tablet by mouth every four hours as needed (PRN) for severe pain initially ordered on December 31, 2024, and discontinued January 2, 2025. Percocet 5mg (narcotic pain medication) one tablet by mouth every eight hours as needed (PRN) for severe pain initially ordered January 19, 2025, and discontinued January 20, 2025. A review of the resident's December 2024 and January 2025 Medication Administration Record (MAR) revealed the following: The PRN Percocet 5/325mg was administered two times in December: December 31, 2024, at 4:18 PM - medication administered for a pain scale of 3 (mild pain). December 31, 2024, at 9:04 PM - medication administered for a pain scale of 5 (moderate pain). The PRN Percocet 5/325mg was administered three times in January:	F 0697		

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F 0697 SS=E	Continued from page 12 January 1, 2025, at 9:04 AM - medication administered for a pain scale of 6 (moderate pain). January 1, 2025, at 5:42 PM - medication administered for a pain scale of 6 (moderate pain). January 6, 2025, at 9:36 AM - medication administered for a pain scale of 6 (moderate pain). The PRN Percocet 5mg was administered once in January: January 19, 2025, at 8:58 PM - medication administered for a pain scale of 3 (mild pain). A further review of the resident's January 2025 MAR revealed that the PRN Percocet was administered a total of four times in January. In all instances, no non-pharmacological interventions were attempted prior to administration. Additionally, three of the four doses were administered for pain levels of mild to moderate pain, despite the medication being prescribed only for severe pain. An interview with the Nursing Home Administrator and Director of Nursing on January 30, 2025, at	F 0697		

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F 0697 SS=E	Continued from page 13 approximately 2:00 PM, confirmed that there was no evidence that non-pharmacological interventions were consistently attempted and documented as ineffective prior to the administration of PRN pain medication. Additionally, they confirmed that the staff administered narcotic pain medication ordered for severe pain to Resident 18 when the resident's documented pain levels were only mild to moderate. The facility administered narcotic pain medication inappropriately for pain levels lower than the prescribed severity and failed to use alternative pain management strategies before resorting to medication. 28 Pa. Code 211.5(f)(vii) Medical records 28 Pa. Code 211.12 (c)(d)(1)(5) Nursing Services	F 0697		
F 0757 SS=D		F 0757		

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F 0757 SS=D	Continued from page 14 483.45(d)(1)-(6) Drug Regimen is Free from Unnecessary Drugs §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by:	F 0757	The facility is unable to correct the findings identified for R34 and R71 To identify other residents that have the potential to be affected, the IP / designee will audit the past 2 weeks for antibiotic's that were ordered to determine if the McGeer's criteria had been completed to clinically justify the use of the antibiotic. Follow up will occur based on the audit findings. To prevent this from reoccurring, the DON / designee will educate the licensed nurses and providers related to providing documented evidence of clinical necessity for administration of an antibiotics and unnecessary medication prescribing practices. To monitor and maintain compliance, the IP / designee will complete audits during the clinical morning meetings for residents with antibiotics ordered to verify there is documented evidence of clinical necessity for ordering the antibiotic. The audits	Completion Date: **02/25/2025** Status: **APPROVED** Date: **02/13/2025**

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F 0757 SS=D	Continued from page 15	F 0757	will be completed 5 days per week times 4 weeks and then weekly times 4. The results of the audits will be forwarded to QAPI committee for further review and recommendations.	

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F 0757 SS=D	Continued from page 16 Based on clinical record and staff interview, it was determined the facility failed to assure the presence of documented evidence of clinical necessity for administration of an antibiotic drug for two residents out of five sampled residents for unnecessary medication prescribing practices (Residents 34 and 71). Findings included: A review of Resident 34's clinical record revealed that the resident was admitted to the facility on February 4, 2023, with diagnoses that included dementia and congestive heart failure (CHF - is a condition where the heart is unable to pump blood effectively). A review of a facility documentation entitled "Infection Control - Infection Tracker with McGeer's Criteria 2024 assessment (an algorithm that uses criteria to make an empiric diagnosis of UTI in nursing home residents. For resident's that do not have an indwelling urinary catheter and with	F 0757		

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F 0757 SS=D	Continued from page 17 at least three of the following signs and symptoms must be present prior to a practitioner prescribing antibiotic therapy include a fever (temperature of at least 38°C [100.4°F]), new or increased frequency, urgency, or burning on urination, new flank or suprapubic pain or tenderness, change in character of urine, and worsening of mental or functional status) dated December 6, 2024, at 3:59 PM, and recorded on December 11, 2024, at 3:59 PM, revealed that the form was initiated due to a suspected UTI. Further review of the completed infection tracker McGeer's Criteria form revealed that Resident 34 did not have a fever, rigors (feeling cold or having chills), or new on-set hypotension (low blood pressure), without alternate site of infection, no acute dysuria (burning sensation when urinating), no leukocytosis (is the presence of more white blood cells than normal, which can indicate infection, inflammation, injury or immune system disorders), and no gross hematuria (presence of red blood cells in the urine), increased incontinence (involuntary loss	F 0757		

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F 0757 SS=D	Continued from page 18 of large or small amounts of urine), increased urgency (need to urinate), or increased frequency). A review of Resident 34's clinical record revealed a nurses' progress note dated December 4, 2024, at 2:17 PM, revealed the facility's contracted CRNP (certified registered nurse practitioner) was in the facility to assess the resident and ordered a urine analysis (UA an analysis that includes various tests to examine the urine contents for any abnormalities that indicate a disease condition or infection)with a culture and sensitivity (C & S 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). Further review of nurses' progress notes dated December 6, 2024, at 2:07 PM, revealed urine culture results showed a result of greater than 100, 000 colonies/ml (significant number of bacteria in the urine that may cause an infection) A review of physician's orders dated December 6, 2024, at 4:56 PM, revealed orders for Cefdinir	F 0757		

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F 0757 SS=D	Continued from page 19 (antibiotics) 300 mg twice per day for seven days related to UTI (urinary tract infection). The resident lacked essential clinical indicators such as fever, dysuria, leukocytosis, or gross hematuria. The only criterion met was a urine culture with >100,000 CFU/mL of a single organism, which alone was insufficient to justify antibiotic therapy. As a result, the resident received fourteen doses of an unnecessary antibiotic. During an interview with the facility's Infection Preventionist (IP) on January 30, 2025, at 11:20 AM, confirmed that Resident 34 did not meet the requirements for antibiotic treatment. A review of Resident 71's clinical record revealed the resident was admitted to the facility on November 5, 2024, with diagnoses that included type II diabetes (a condition results from insufficient production of insulin, causing high blood sugar), dysphagia (difficulty swallowing), and cerebral infarction with weakness (a medical condition that	F 0757		

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F 0757 SS=D	Continued from page 20 occurs when the blood flow to the brain is disrupted due to issues with the arteries that supply it and the lack of sufficient blood supply to brain cells deprives them of oxygen and critical nutrients, potentially leading to the death of brain cells). A review of nurses' progress notes in Resident 71's clinical record dated November 15, 2024, at 9:35 PM, revealed the resident was catheterized (is a medical procedure used to drain the bladder) to obtain urine specimen (refers to a sample of urine collection from a patient for diagnostic tests).A CBC (complete blood count that checks different arts of the blood such as the white blood cells to identify infection). A physician's order for Rocephin (antibiotic) IM (intramuscular injection that delivers medication deep into muscle tissue, allowing rapid absorption). A review of the resident's laboratory results dated November 17, 2024, at 8:27 AM, revealed the urinalysis results were unremarkable, urine culture showed no growth, and WBC (white blood cells	F 0757		

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F 0757 SS=D	Continued from page 21 measures the number of white blood cells in your blood, which are part of your immune system) elevated at 13.05 (reference range for normal parameters 4.0 - 10.80). Additionally, nursing progress notes dated November 16, 2024, through November 18, 2024, documented that the Resident 71's vital signs (temperature, pulse, blood pressure, and respirations) were documented within normal parameters. Rocephin was administered for two days without meeting McGeer's Criteria or having laboratory evidence of an infection During an interview with the facility's Director of Nursing (DON) on January 30, 2025, at 1:15 PM, reported that prior to initiating an antibiotic and as a part of the facility's antibiotic stewardship program licensed nursing staff did not complete the required "Infection Tracker form with McGeer's Criteria - 2024" to clinically justify the use of an antibiotic.	F 0757		

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F 0757 SS=D	Continued from page 22 Additionally, the DON reported that staff did not complete the form as per the antibiotic stewardship program and confirmed that Resident 71's prescribing physician was aware that his signs and symptoms did not meet McGeer's protocol for prescribing an antibiotic. The DON confirmed the facility failed to assure that Resident 71's medication regimen was free from unnecessary medications, Rocephin, and failed to meet antibiotic prescribing practices. 28 Pa. Code 211.2 (3) Medical Director 28 Pa. Code 211.9 (k) Pharmacy Services 28 Pa. Code 211.12 (d)(1)(3) Nursing Services	F 0757		
F 0791 SS=D		F 0791		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0791 SS=D	Continued from page 23 483.55(b)(1)-(5) Routine/Emergency Dental Srvcs in NFs §483.55 Dental Services The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(b) Nursing Facilities. The facility- §483.55(b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(f) of this part, the following dental services to meet the needs of each resident: (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services; §483.55(b)(2) Must, if necessary or if requested, assist the resident- (i) In making appointments; and (ii) By arranging for transportation to and from the dental services locations; §483.55(b)(3) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay;	F 0791	Resident 23 routine dental service has been scheduled To identify other residents that have the potential to be affected, the Social Service Director will complete a list of current long-term residents' last annual dental appointment and schedule each resident's routine dental services as they become due from the last routine dental appointment. To prevent this from re-occurring, the Social Service Director will maintain a spreadsheet of current long-term residents last routine dental appointment and ensure the next annual routine is scheduled timely each year. To monitor and maintain compliance the Social Service Director will report at the monthly QAPI meeting the residents who are scheduled in the upcoming month to have routine dental services. The spreadsheet will be audited by NHA/ designee weekly times 4 weeks and then	Completion Date: **02/25/2025** Status: **APPROVED** Date: **02/13/2025**

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F 0791 SS=D	Continued from page 24 §483.55(b)(4) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; and §483.55(b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan. This REQUIREMENT is not met as evidenced by:	F 0791	monthly times 2. The results of the audits will be forwarded to QAPI committee for further review and recommendations.	

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F 0791 SS=D	Continued from page 25 Based on review of clinical records and staff interview, it was determined the facility failed to offer routine annual dental services for one Medicaid payor source (Resident 23) out of 19 sampled residents. Findings include: Review of Resident 23's clinical record revealed admission to the facility on September 7, 2018, and the resident's payor source was Medicaid. A review of nurses' progress notes in the resident's clinical record dated July 31, 2024, at 1:39 PM, revealed that the facility's contracted CRNP (certified registered nurse practitioner) in to see resident due to complaints of left sided facial pain. NON (new orders noted) for Clindamycin (is a medication used to treat a wide variety of bacterial infections) 300 mg PO (orally) every six hours for 7 days for parotitis (is a serious gum infection that damages the soft tissue around teeth).	F 0791		

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F 0791 SS=D	Continued from page 26 Further review of Resident 23's clinical record failed to reveal that the facility offered dental services from November 16, 2022, until October 20, 2024. During an interview with the Director of Nursing (DON)on November 30, 2025, at 9:20 AM, confirmed that the facility failed to assure that Resident 23 was annually offered routine dental services. 28 Pa. Code 211.12 (c)(d)(3)(5) Nursing services	F 0791		
F 0881 SS=E		F 0881		

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F 0881 SS=E	Continued from page 27 483.80(a)(3) Antibiotic Stewardship Program §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. This REQUIREMENT is not met as evidenced by:	F 0881	The facility is unable to correct the findings identified for R34 and R71 To identify other residents that have the potential to be affected, the IP / designee will audit the past 2 weeks for antibiotic's that were ordered to determine if the McGeer's criteria had been completed to clinically justify the use of the antibiotic. Follow up will occur based on the audit findings. To prevent this from reoccurring, the DON / designee will educate the IP and licensed nurses on consistent implementation of the antibiotic stewardship protocols for initiating antibiotic use in accordance with the established infection prevention and control guidelines. To monitor and maintain compliance, the DON / designee will conduct audits of the IP's logs to ensure adherence to established antibiotic stewardship program including clinical justification for use. The audits will be completed weekly	Completion Date: **02/25/2025** Status: **APPROVED** Date: **02/13/2025**

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F 0881 SS=E	Continued from page 28	F 0881	times 4 weeks and then monthly times 3. The results of the audits will be forwarded to QAPI committee for further review and recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0881 SS=E	Continued from page 29 Based on a review of clinical records, staff interview, facility policy, and the facility's infection assessment tool, it was determined the facility failed to consistently implement its antibiotic stewardship protocols for initiating antibiotic use in accordance with the established infection prevention and control guidelines for two residents out of 19 sampled (Residents 34 and 71). Findings included: A review of a facility policy entitled "Antibiotic Stewardship" last reviewed December 2024, indicated that antibiotics will be prescribed and administered to residents under the guidance of the facility's Antibiotic Stewardship Program. The policy stated the facility will monitor and track new antibiotics start rates and antibiotic days of therapy monthly. It also required that antibiotic use protocols address prescribing practices, including documentation of the indication, dose, and duration of the antibiotic, review of laboratory reports to determine necessity, and completion of an infection	F 0881		

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F 0881 SS=E	Continued from page 30 assessment before prescribing. Additionally, the policy outlined monitoring procedures such as antibiotic use reports, antibiotic resistance reports, and the use of McGeer's criteria for determining the need for antibiotic therapy. A review of Resident 34's clinical record revealed that the resident was admitted to the facility on February 4, 2023, with diagnoses that included dementia and congestive heart failure (CHF - is a condition where the heart is unable to pump blood effectively). A review of the facility's infection tracker form, entitled "Infection Control - Infection Tracker with McGeer's Criteria," dated December 6, 2024, and recorded on December 11, 2024, indicated that the form was initiated due to a suspected urinary tract infection (UTI). However, the completed assessment revealed that Resident 34 did not meet the McGeer's criteria to support the initiation of antibiotic therapy. Specifically, the resident did not have a fever, rigors, acute dysuria, leukocytosis,	F 0881		

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F 0881 SS=E	Continued from page 31 gross hematuria, or other signs and symptoms necessary to meet at least three criteria for a UTI diagnosis. Despite only meeting one criterion, a physician's order dated December 6, 2024, at 4:56 PM, prescribed Cefdinir 300 mg orally twice per day for seven days. A review of Resident 34's Medication Administration Record (MAR) for December 2024 revealed that the resident received 14 doses of Cefdinir without meeting the documented criteria for initiation of antibiotic therapy. The facility's failure to adhere to antibiotic stewardship protocols resulted in the unnecessary administration of antibiotics. A review of Resident 71's clinical record revealed that the resident was admitted to the facility on November 5, 2024, with diagnoses that included type II diabetes (a condition results from insufficient production of insulin, causing high blood sugar), dysphagia (difficulty swallowing), and cerebral infarction with weakness (is a medical condition that occurs when the blood flow to the brain is disrupted	F 0881		

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F 0881 SS=E	Continued from page 32 due to issues with the arteries that supply it and the lack of sufficient blood supply to brain cells deprives them of oxygen and critical nutrients, potentially leading to the death of brain cells). A nursing progress note dated November 15, 2024, at 9:35 PM, indicated that Resident 71 was catheterized ((is a medical procedure used to drain the bladder) to obtain a urine specimen. Orders were noted for STAT laboratory testing, including a complete blood count (CBC) and a basic metabolic panel (BMP), as well as an order to initiate Rocephin 1 gram intramuscularly daily for two days due to an elevated white blood cell (WBC) count. A review of the resident's laboratory results dated November 17, 2024, at 8:27 AM, revealed that urinalysis results were unremarkable, the urine culture showed no growth, and WBC was elevated at 13.05 (reference range: 4.0 - 10.80). However, nursing progress notes from November 16, 2024, through November 18, 2024, documented that the resident's vital signs, including temperature, pulse,	F 0881		

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	395067	A. BLDG: __00_____ B. WING: _____	01/31/2025

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GREEN RIDGE CARE CENTER STATE LICENSE NUMBER: **332302**	**2741 BOULEVARD AVENUE SCRANTON, PA 18509**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0881 SS=E	Continued from page 33 blood pressure, and respirations, remained within normal parameters. Despite the lack of clinical signs or symptoms of infection, the resident received two doses of Rocephin, indicating the facility's failure to ensure antibiotic therapy was supported by documented clinical necessity. During an interview with the facility's Infection Preventionist (IP) on January 30, 2025, at 11:20 AM, confirmed that the facility failed to implement antibiotic stewardship protocols for residents 34 and 71. This failure contributed to the initiation and continuation of antibiotic therapy without documented evidence of clinical necessity, inconsistent use of infection surveillance tools, and noncompliance with infection prevention and control guidelines. The facility failed to adhere to its established antibiotic stewardship program by allowing the initiation and continuation of antibiotic therapy without documented clinical indications. guidelines. Cross Refer F757	F 0881		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395067	A. BLDG: __00_____ B. WING: _____	01/31/2025

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F 0881 SS=E	Continued from page 34 28 Pa. Code 211.10(a)(d) Resident care policies 28 Pa. Code 211.12 (c)(d)(1)(3)(5) Nursing services	F 0881		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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P 5530		P 5530		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: | (X6) DATE:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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P 5530	Continued from page 1 Nursing services. (4) Effective July 1, 2023, a minimum of 1 LPN per 25 residents during the day, 1 LPN per 30 residents during the evening, and 1 LPN per 40 residents overnight. This REGULATION is not met as evidenced by:	P 5530	The facility is unable to retroactively correct the cited issue. Staffing meetings will be held 5 days a week with the scheduler, Director of Nursing and Nursing Home Administrator, to review the current day LPN staffing ratios and upcoming week to ensure appropriate staffing levels for LPN staffing ratios for each shift. The facility is focusing on retention of existing LPNs and recruitment of new LPN nurses through the efforts of the Human Resources manager and the Administrator working on facility recruitment and retention plan to maintain required state ratios. If the projected staffing ratios do not meet minimum, then the facility will reach out to current staff and local staffing agencies using as needed bonuses to enlist staff or agency staff to meet the minimum requirement. The facility will continue to recruit staff through all platforms.	Completion Date: **02/25/2025** Status: **APPROVED** Date: **02/13/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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P 5530	Continued from page 2	P 5530	Daily audits of the schedules will be conducted for 7 days for 2 weeks and weekly for 2 months. The results will be reviewed at Quality Assurance and Performance Improvement meetings until substantial compliance of the state ratio can be met through the hiring and retention plan.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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P 5530	Continued from page 3 Based on a review of nurse staffing and staff interview, it was determined the facility failed to ensure the minimum licensed practical nurse staff to resident ratio was provided on each shift for two shifts out of 21 shifts reviewed. Findings include: A review of the facility's weekly staffing records revealed that on the following dates the facility failed to provide minimum licensed practical nurse (LPN) staff of 1:25 on the day shift; 1:30 on the evening shift; and 1:40 on the night shift. January 23, 2025 - 3.03 LPNs on the day shift, versus the required 3.72 for a census of 93. January 26, 2025 - 2.28 LPNs on the night shift, versus the required 2.35 for a census of 94. On the above dates mentioned, no additional excess higher-level staff were available to compensate this deficiency.	P 5530		

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P 5530	Continued from page 4 An interview with the Nursing Home Administrator on January 31, 2025, at approximately 12:00 PM, confirmed the facility had not met the required LPN to resident ratios on the above dates.	P 5530		

Certified End Page

GREEN RIDGE CARE CENTER

STATE LICENSE NUMBER: 332302

SURVEY EXIT DATE: 01/31/2025

I Certify This Document to be a True and Correct Statement of Deficiencies and Approved Facility Plan of Correction for the Above-Identified Facility Survey

Jeanne Parisi
Deputy Secretary for Quality Assurance

Debra L. Bogen MD
Debra L. Bogen, MD, FAAP
Secretary of Health

Pennsylvania
Department of Health

THIS IS A CERTIFICATION PAGE

PLEASE DO NOT DETACH

THIS PAGE IS NOW PART OF THIS SURVEY