STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395103	A. BLDG: 00 B. WING:	01/24/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
ELAN SKILLED NURSING AND REHAB, A JEWISH SENIOR LIFE COMMUNI STATE LICENSE NUMBER: **360402**	**1101 VINE STREET SCRANTON, PA 18510**

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F 0000	INITIAL COMMENT Based on a Medicare/Medicaid Recertification, State Licensure, and Civil Rights Compliance survey completed on January 24, 2025, it was determined that Elan Skilled Nursing and Rehab was not in compliance with the following requirements of 42 CFR Part 483 Subpart B Requirements for Long Term Care and the 28 PA Code Commonwealth of Pennsylvania Long Term Care Licensure Regulations.	F 0000		
F 0584 SS=D		F 0584		

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.

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F 0584 SS=D	Continued from page 1 483.10(i)(1)-(7) Safe/Clean/Comfortable/Homelike Environment §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all	F 0584	1. The immediate corrective action for the identified Broda chair: the seat, footrest, and wheels were cleaned. Also, the fall mat in room 504 was replaced. 2. EVS Director or designee will conduct an initial audit of all Broda chairs and floor mats will be conducted to identify other residents who may have the potential to be affected by deficient practice. 3. All EVS staff will be educated regarding the scheduled cleaning of Broda chairs. All nursing staff will be educated to identify and rectify fall mats that are in poor condition. 4. EVS Director or designee will audit All Broda chairs and floor mats weekly for four (4) weeks then monthly until substantial compliance is achieved. All results will be submitted and reviewed in QAPI.	Completion Date: **03/06/2025** Status: **APPROVED** Date: **02/07/2025**

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F 0584 SS=D	Continued from page 2 areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by:	F 0584		

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F 0584 SS=D	Continued from page 3 Based on observation, and staff interviews it was determined the facility failed to provide housekeeping and maintenance services to maintain a clean and safe resident environment on one of four resident care units (5th floor). Findings include: An observation on January 23, 2024, at approximately 9:40 AM revealed in a Broda chair in the hallway outside room 504 revealed the following: The seat of the chair was heavily soiled with a crusty orange substance. The footrest was heavily soiled with a dried white and brown substance. The rear wheels were heavily soiled with dirt and debris with a significant amount of hair entangled in the base. Further observation of room 504 revealed a fall mat on the floor beside the resident's bed (nearest the	F 0584		

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F 0584 SS=D	Continued from page 4 door). The mat had large tears at its folding point and on the front corner, exposing the internal foam. Interview with Employee 1, licensed practical nurse, on January 23, 2024, at approximately 9:50 AM, confirmed the observations. Interview with the Director of Nursing and Nursing Home Administrator on January 23, 2024, at approximately 1:30 PM both confirmed that resident care equipment is to be maintained in a clean and sanitary manner. 28 Pa. Code 201.18 (e)(2.1) Management	F 0584		
F 0600 SS=D		F 0600		

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F 0600 SS=D	Continued from page 5 483.12(a)(1) Free from Abuse and Neglect §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by:	F 0600	1. Resident 289 was discharged from the facility on 10/26/2024. A referral to psych services made for Resident 102 and an IDT approach continues. Resident 25 sustained no injury related to fall. Resident 25 was monitored for 72hrs and no change in condition was noted. Employee 6 was educated regarding reading residents' Kardex prior to providing care as well as abuse and neglect. 2. Residents of the facility have the potential to be affected by deficient practice. Staff records will be audited for Abuse/Neglect training over the past 12 months. Clinical Coordinator or designee will review new-hire CNA records for training in reading and adherence to the resident plan of care. 3. CNAs will be educated regarding adherence to the resident's plan of care. Facility staff will be educated regarding Abuse and Neglect upon hire and annually. 4. Director of Nursing or designee will audit all changes to the resident Kardex and Tasks five (5) times per week during the business week for	Completion Date: **03/06/2025** Status: **APPROVED** Date: **02/10/2025**

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F 0600 SS=D	Continued from page 6	F 0600	two (2) weeks then weekly for four (4) weeks until substantial compliance is achieved. All results will be submitted and reviewed in QAPI.	

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F 0600 SS=D	Continued from page 7 Based on a review of facility's abuse policy, clinical records, and select investigative reports and staff interview it was determined the facility failed to assure that one resident (Resident 289) was free from sexual abuse perpetrated by another resident (Resident 102) and one resident (Resident 25) was free from neglect out of 27 residents sampled. Findings included: A review of the current facility policy titled "Abuse Prohibition", last reviewed by the facility on September 6, 2024, revealed it is the policy of the facility to provide a safe environment where residents are not subject to mental, physical, sexual, and verbal abuse or neglect by staff, residents, volunteers, consultants, contractors, and other caregivers, visitors or family members. The current policy titled "Identifying Types of Abuse" last reviewed by the facility on September 6, 2024, defined sexual abuse as non-consensual sexual conduct of any type with a resident. Sexual	F 0600		

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F 0600 SS=D	Continued from page 8 abuse includes, but is not limited to: a. Unwanted intimate touching of any kind especially of breasts or perineal area. b. All types of sexual assault or battery, such as rape, sodomy, and coerced nudity. c. Forced observation of masturbation and/or pornography; and d. Taking sexually explicit photographs and/or audio/video recordings of a resident(s) and maintaining and/or distributing them. This would include, but is not limited to, nudity, fondling, and/or intercourse involving a resident. A review of Resident 102's clinical record revealed admission to the facility on September 21, 2024, with diagnoses to include chronic obstructive pulmonary disease (lung disease that blocks airflow and makes it difficult to breathe), hypertension (high blood pressure), and depression. An admission Minimum Data Set assessment (MDS-a federally mandated standardized assessment completed periodically to plan resident	F 0600		

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F 0600 SS=D	Continued from page 9 care) dated September 27, 2024, indicated the resident was moderately cognitively impaired with a BIMS (brief interview of mental status to a tool to assess the resident's attention, orientation and ability to register and recall new information) a score of 9 (8-12 represents moderate cognitive impairment). Facility documentation indicated a pattern of sexually inappropriate behaviors by Resident 102 prior to the reported incident involving Resident 289: A review of nursing documentation dated September 24, 2024, at 12:27 PM revealed Resident 102 was noted to be sitting close to Resident 91 and making inappropriate comments and gestures of a sexual nature while speaking to her. The nurse approached Resident 102 and explained that his behaviors are inappropriate. Redirection provided with positive effect. A review of nursing documentation On September 26, 2024, at 1:19 AM, Resident 102 was observed	F 0600		

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F 0600 SS=D	Continued from page 10 naked in the hallway and attempting to enter another resident's room. Resident 102 placed his soiled brief next to a resident's door. Nurse aides provided incontinence care to the resident, and he returned to bed. A review of Resident 102's plan of care, initiated October 3, 2024, revealed the resident had the potential to be verbally aggressive due to dementia, ineffective coping skills, poor impulse control as evidenced by his use of socially inappropriate statements and language, negative statements toward others, and overhead making sexually explicit comments to a female resident. Care plan interventions were as follows: Providing privacy and emotional support as needed. Redirecting him with conversations about his job. Reinforcing that staff are present to assist with care and are honest in their communication. Identifying and minimizing triggers for verbal aggression, such as noise levels. Offering a tour of his surroundings to help	F 0600		

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F 0600 SS=D	Continued from page 11 de-escalate behaviors. Encouraging him to call his daughter. Supporting participation in activities. Assessing his understanding of situations and behaviors. Encouraging him to express his thoughts and feelings. Providing choices regarding care and activities. Reinforcing positive behaviors with appropriate encouragement A review of Resident 289's clinical record revealed admission to the facility on October 4, 2024, with diagnoses to include Alzheimer's disease (a progressive brain disease that destroys memory and other important mental functions). An admission MDS dated October 10, 2024, revealed the resident was severely cognitively impaired with a BIMS score of 3 (a score of 0-7 indicates severe cognitive impairment). Resident 289 did not possess the mental capacity to consent to sexual contact and activity.	F 0600		

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F 0600 SS=D	Continued from page 12 A review of the Employee 4 (licensed practical nurse) witness statement dated October 7, 2024, at 9:30 AM revealed that Resident 102 was observed in the lunchroom with Resident 289. Resident 289's hand was on Resident 102's lap, while Resident 102 was holding Resident 289's hand on his genital region. Staff immediately intervened, separating the two residents. Resident 289 expressed discomfort and confusion about the incident, stating that it was "gross" and that they did not understand why it had occurred. Social Services was contacted right away to address the situation. A review of facility documentation dated October 9, 2024, at 4:12 PM showed that the Director of Nursing (DON) was informed of a staff-written statement regarding an incident that occurred on October 8, 2024. The statement described a reportable event, prompting an ongoing investigation. The physician was notified, and the incident was reported to the Department of Health and local law enforcement. The facility also reported the event to Adult Protective Services (AAA).	F 0600		

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F 0600 SS=D	Continued from page 13 Resident 289's representative was contacted and informed of the situation. Emotional support was provided to Resident 289, who did not recall the incident. As a precautionary measure, Resident 289 was placed on fifteen-minute safety checks, and staff were instructed to ensure that Resident 289 and Resident 102 remained separated. Despite the incident occurring on October 7th 2024 documentation regarding the event and the decision to implement safety measures was not completed until October 9th 2024 resulting in a 2 day delay in reporting and intervention. Interview with the Clinical Operations Executive on January 24, 2025, at approximately 11:15 AM confirmed that Resident 102 displayed sexually inappropriate behaviors, and that the facility failed to ensure that Resident 289 was free from sexual harassment perpetrated by Resident 102 by not implementing sufficient interventions to address Resident 102's identified pattern of inappropriate behaviors.	F 0600		

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F 0600 SS=D	Continued from page 14 Review of clinical record revealed Resident 25 was admitted to the facility on February 1, 2020, with diagnoses which included depression, arthritis, and dementia (loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life). Review of the plan of care for Resident 25 revealed that the resident required the assist of 2 staff members and the use of a sit-to-stand lift for toileting and transfers. Review of facility investigation dated December 26, 2024, at 10:30 AM, revealed that Resident 25 was assisted to the bathroom by Employee 6, nurse aide. Review of witness statement completed by Employee 6, she assisted Resident 25 out of his wheelchair "by putting my whole right arm under his right arm". Employee 6 then proceeded to walk the resident to the bathroom with the assistance of a walker, "he got unsteady on his feet and began to	F 0600		

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F 0600 SS=D	Continued from page 15 slowly go backwards. I tried to catch him to ease the fall. He landed on his bottom". Review of witness statement completed by Employee 1, LPN, dated December 23, 2024, indicated that "when resident was assigned to new aide, aide was advised he was an Apex [sit-to-stand lift]. Review of personnel file for Employee 6 revealed a hire date of November 5, 2024. According to the employee's file, education was provided regarding the facility's abuse policy and procedures upon hire. Interview with the Director of Nursing on January 24, 2025, at 11 AM confirmed that Employee 6 failed to follow Resident 25's plan of care which resulted in a fall without injury. 28 Pa. Code 201.29 (a)(c) Resident rights 28 Pa. Code 201.18 (e)(1) Management	F 0600		

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F 0600 SS=D	Continued from page 16 28 Pa. Code 211.12 (c)(d)(3)(5) Nursing services	F 0600		
F 0607 SS=D		F 0607		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395103	A. BLDG: 00 B. WING:	01/24/2025

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F 0607 SS=D	Continued from page 17 483.12(b)(1)-(5)(ii)(iii) Develop/Implement Abuse/Neglect Policies §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, §483.12(b)(4) Establish coordination with the QAPI program required under §483.75. §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements. §483.12(b)(5)(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act. §483.12(b)(5)(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act.	F 0607	1. Resident 289 was discharged from the facility on 10/26/2024. A referral for psychological services made for Resident 102 and an interdisciplinary approach continues. 2. Facility residents have the potential to be affected by deficient practice. The facility will identify other residents on the affected unit to assess their ability to consent. Any resident without the ability to consent will be monitored for safety. The facility will continue to conduct sex offender checks for new admissions prior to facility acceptance with completion of the Trauma Informed Care evaluation upon admission, to determine resident history of and risk for abuse. 3. Facility staff will be educated regarding Abuse and Neglect policies and procedures, specifically, the reporting guidelines upon hire and annually, focusing on immediate identification, reporting of abuse, and initiating interventions for monitoring and preventing	Completion Date: **03/06/2025** Status: **APPROVED** Date: **02/11/2025**

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F 0607 SS=D	Continued from page 18 This REQUIREMENT is not met as evidenced by:	F 0607	recurrence by the facility. 4. Documentation and concern forms will be reviewed daily during the business week for four (4) weeks to identify any potential areas of concern then weekly until substantial compliance is achieved. Audit results will be submitted and reviewed by the Quality Assurance Performance Improvement committee.	

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F 0607 SS=D	Continued from page 19 review, and staff interview it was revealed the facility failed to implement its abuse prohibition procedures to identify potential sexual abuse, timely notify administration and the State Survey Agency, report to the resident representatives and physician, and promptly investigate alleged sexual abuse of one resident out of 27 sampled (Resident 289). Findings include: Review of the facility policy titled "Abuse Prohibition" last reviewed September 6, 2024, revealed all allegations of abuse shall be reported immediately to the Charge Nurse, Director of Nursing, Administrator, and resident's physician for investigation into the circumstances of the incident. The staff member who discovers the incident, suspected abuse situation or has the initial knowledge of such incidents will be responsible for immediately notifying his or her supervisor. The supervisor who becomes aware of such incidents must immediately report to the Administrator and Director of Nursing, in person or by telephone.	F 0607		

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F 0607 SS=D	Continued from page 20 The facility's abuse policy defines sexual abuse as non-consensual sexual contact of any type with a resident. Further review of the policy revealed that The Administrator and/or Director of Nursing must immediately report (no later than 2 hours after the allegation is made) the incident to the following agencies accordingly: a. Orally by telephone and fax to Area of Agency (AAA) b. Electronically to the Department of Health via the electronic reporting site c. Make an oral report to the statewide Protective Services Hotline d. Incidents involving sexual abuse, sexual assault or serious physical bodily injury must also be reported immediately to the local law enforcement agency and Pennsylvania Department of Aging. Facility documentation dated October 7, 2024, at 9:30 AM, indicated that Resident 102 was	F 0607		

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F 0607 SS=D	Continued from page 21 observed in the lunchroom holding Resident 289's hand on his genital region. Resident 289 stated, "That was gross, I don't understand why he did that." Social Services was contacted immediately. A review of a nurse's note dated October 9, 2024, at 4:12 PM indicated that the DON became aware of an October 8, 2024, written staff statement referencing a reportable event involving Resident 289. The note documented that: The physician was notified, The incident was reported to the Department of Health and local Police, The resident representative was contacted, and The resident was placed on fifteen-minute safety checks. Despite facility policy requiring immediate reporting within two hours, the facility failed to report the allegation until October 9, 2024-two days after the incident occurred.	F 0607		

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F 0607 SS=D	Continued from page 22 A review of Employee 5 (Admissions Director) interview with Resident 102 dated October 7, 2024 (no time indicated) revealed the resident was moderately cognitively impaired and denies any touching of anyone/and/or any female resident. A review of the clinical record of Resident 289 revealed the resident was severely cognitively impaired and lacked the ability to consent to sexual activity. A review of Resident 289's clinical record revealed: No documentation that the alleged sexual encounter had occurred. No evidence that the facility's administrator, DON, attending physician, or the resident's responsible party were notified at the time of the incident. A review of Resident 102's clinical record also revealed: No documentation of the alleged sexual encounter. No documentation the administrator, DON, attending physician, or responsible party was	F 0607		

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F 0607 SS=D	Continued from page 23 notified. Additionally, there was no documented evidence the facility developed and implemented a plan to prevent future occurrences and protect Resident 289 and other female residents from Resident 102's inappropriate sexual behavior. A review of the facility's abuse investigation records revealed the facility did not begin investigating the alleged sexual encounter of Resident 289 by Resident 102 abuse until October 9, 2024-two days after the incident. Per facility policy, investigations should begin immediately following an allegation of abuse. Interview with Clinical Operations Executive on January 24, 2025, at approximately 11:15 AM it was confirmed the facility failed to follow its abuse reporting and investigation policies in response to the alleged sexual abuse of Resident 289 by Resident 102. The facility failed to implement its abuse prevention and reporting policies by not immediately identifying, reporting, and investigating	F 0607		

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F 0607 SS=D	Continued from page 24 an allegation of sexual abuse 28 Pa. Code 201.18 (e)(1) Management. 28 Pa. Code 201.29 (a)(c) Resident Rights. 28 Pa. Code 201.14(a)(c) Responsibility of Licensee. 28 Pa. Code: 211.12 (c)(d)(1)(3)(5)Nursing Services	F 0607		
F 0625 SS=E		F 0625		

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F 0625 SS=E	Continued from page 25 483.15(d)(1)(2) Notice of Bed Hold Policy Before/Upon Trnsfr §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by:	F 0625	1. Residents 27, 102, and 124 are MA or MAP residents and did not lose their assigned beds while out at the hospital. We are unable to correct those past occurrences. 2. All residents who transfer out to the hospital or on therapeutic leave have the potential to be affected by deficient practice. 3. All nursing staff will be educated regarding the bed hold policy and procedure. The business office and social services have been educated regarding the electronic completion of the bed hold notice. 4. Business Office Manager or designee will audit all transfers out of the building and therapeutic leaves daily during the business week for four (4) weeks then weekly until substantial compliance is achieved. All results will be submitted and reviewed in QAPI.	Completion Date: **03/06/2025** Status: **APPROVED** Date: **02/07/2025**

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F 0625 SS=E	Continued from page 26	F 0625		

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F 0625 SS=E	Continued from page 27 Based on a review of clinical records and staff interview it was determined the facility failed to provide residents or their representatives with written information of the facility's bed hold policy upon transfer to the hospital of three residents out of 27 residents sampled (Residents 27, 124, and 102). Findings include: A review of Resident 27's clinical record revealed the resident was transferred to the hospital on November 27, 2024, and returned to the facility on December 3, 2024. A review of Resident 124's clinical record revealed the resident was transferred to the hospital on November 26, 2024, and returned to the facility on November 29, 2024. A review of Resident 102's clinical record revealed the resident was transferred to the hospital on December 10, 2024, and returned to the facility on December 13, 2024.	F 0625		

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F 0625 SS=E	Continued from page 28 There was no documented evidence the facility provided these residents and/or their representatives written information about the facility's bed-hold policy (an agreement for the facility to hold a bed for an agreed upon rate during a hospitalization) at the time of transfer. Interview with the Clinical Operations Executive on January 23, 2025, at 12:45 PM confirmed the facility was unable to provide documented evidence of the provision of written notice of the facility's bed hold policy upon hospital transfer. 28 Pa Code 201.18 (e)(1) Management 28 Pa Code 201.29 (b) Resident rights	F 0625		
F 0684 SS=E		F 0684		

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F 0684 SS=E	Continued from page 29 483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by:	F 0684	1. There is no way for the facility to retroactively address resident #121's supplemental documentation. Drug was discontinued on 01/16/2025. Resident # 124's heartrate and blood pressure parameters, per physician order, were added to the physicians order effective 01/23/2025. Nursing staff is collecting this clinical information and administering based on parameters. Resident # 46's heartrate and blood pressure parameters, per physician order, were added to the physicians' orders effective 01/23/2025. Nursing staff is collecting this clinical information and administering based on parameters. 2. A review was completed by the Director of Nursing on 02/05/2025 of vasoactive, antiarrhythmics, and antihypertensive orders for in-house residents to assure clinical parameters, as ordered by the physician, are in place and being utilized in the administration of the	Completion Date: **03/06/2025** Status: **APPROVED** Date: **02/11/2025**

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F 0684 SS=E	Continued from page 30	F 0684	medications. 3. The Clinical Coordinator or designee will educate licensed nursing staff regarding the requirement to assure clinical parameters for medication, as ordered by the physician, are in place and being utilized in the administration of the medications. 4. The DON or designee will complete a weekly review of vasoactive, antiarrhythmics, and antihypertensives for newly admitted and current in-house residents to assure clinical parameters for medication, as ordered by the physician, are in place and being utilized in the administration of the medications. This review will continue weekly for the next three months. Audit results will be reported to the Quality Assurance Performance Improvement committee monthly for three months to ensure continued compliance.	

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F 0684 SS=E	Continued from page 31 Based on clinical record review and staff interview, it was determined the facility failed to follow physician orders for medication administration for three resident out of 27 sampled (Resident 121, 124, and 46). Findings include: According to the Pennsylvania Code, Title 49, Professional and Vocational Standards, State Board of Nursing, 21.11 (a)(1)(2)(4) indicates that the registered nurse was to carry out nursing care actions that promote, maintain, and restore the well-being of individuals. The Pennsylvania Code, Title 49, Professional and Vocational Standards, State Board of Nursing, 21.145 Functions of the Licensed Practical Nurse (LPN) (a) The LPN is prepared to function as a member of the health-care team by exercising sound judgement based on preparation, knowledge, skills, understandings and past experiences in nursing situations. The LPN participates in the planning,	F 0684		

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F 0684 SS=E	Continued from page 32 implementation, and evaluation of nursing care in settings where nursing takes place. 21.148 Standards of nursing conduct (a) A licensed practical nurse shall: (5) Document and maintain accurate records. Review of the facility policy titled "Medication Administration" last reviewed by the facility on September 6, 2024, revealed that the licensed nurse will administer medications following the Rights of Medication Administration listed below: a. Right Drug b. Right Resident c. Right Time d. Right Dose e. Right Route f. Right Dosage Form. g. Right Reason A review of Resident 121's clinical record revealed the resident was admitted to the facility on April 30, 2024, with diagnoses to include hypertension (high blood pressure) and end stage renal disease (final,	F 0684		

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(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 0684 SS=E	Continued from page 33 permanent stage of chronic kidney disease, where the kidneys can no longer function on their own). A physician order dated December 23, 2024, and discontinued January 16, 2025, was noted for Carvedilol Tablet (used to treat high blood pressure) 6.25 milligrams (mg) daily. Give one tablet by mouth two times a day related to hypertension. Hold this medication if the resident's systolic blood pressure is less than 100 millimeters of mercury (mm Hg) or heart rate is less than 60 beats per minute. Review of the resident's corresponding Medication Administration Records for the months of December 2024, and January 2025, revealed the medication was being administered without documented evidence the resident's blood pressure and/or heart rate had been obtained prior in accordance with physician's orders from December 23, 2024 to January 16, 2025. A review of Resident 124's clinical record revealed the resident was admitted to the facility on March 6,	F 0684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395103	A. BLDG: 00 B. WING:	01/24/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
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F 0684 SS=E	Continued from page 34 2024, with diagnoses to include hypertension (high blood pressure) and chronic atrial fibrillation (an irregular, often rapid heart rate that commonly causes poor blood flow). A physician order dated November 29, 2024, remaining current at the time of the survey, was noted for Atenolol tablet (used to treat high blood pressure) 25 milligrams (mg). Give one tablet by mouth one time a day for hypertension. Hold this medication if the resident's systolic blood pressure is less than 100 millimeters of mercury (mm Hg) or heart rate is less than 60 beats per minute. Review of the resident's corresponding Medication Administration Records for the months of November 2024, December 2024, and January 2025, revealed the medication was being administered without documented evidence the resident's blood pressure and/or heart rate had been consistently obtained prior in accordance with physician's orders from November 29, 2024.	F 0684		

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F 0684 SS=E	Continued from page 35 Review of Resident 46's clinical record revealed the resident was admitted to the facility on April 12, 2024, with diagnoses which included hypertension, depression, and dementia (loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life). A physician order dated April 15, 2024, remaining current at the time of the survey ending January 24, 2025, was noted for metoprolol tartrate 25mg orally two times a day for hypertension. Instructions included to hold the medication for a blood pressure less than 100 and heart rate less than 60. Further review of the physician orders revealed an additional order dated April 15, 2024, for Norvasc 5mg orally two times a day for hypertension. Instructions for administration were to hold the medication for a systolic blood pressure less than 110 and a heart rate less than 60. A review of the resident's Medication	F 0684		

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F 0684 SS=E	Continued from page 36 Administration Records dated December 2024 and January 2025 failed to provide evidence that Resident 46's blood pressure or heart rate was monitored prior to the administration of the antihypertensive medications. Interview with the Clinical Operations Executive on January 23, 2025, at 9:30 AM verified that nursing staff failed to consistently obtain Residents 121, 124 and 46 blood pressure and /or heart rate prior to administering the medication to ensure its necessity and adherence to physician prescribed parameters for administration. 28 Pa. Code 211.12 (c)(d)(1)(3)(5) Nursing services 28 Pa. Code 211.5(f)(i)(x)(xi) Medical records 28 Pa. Code 211.9 (a)(1)(d) Pharmacy services 28 Pa. Code 211.10(c) Resident care policies	F 0684		

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F 0684 SS=E	Continued from page 37	F 0684		
F 0692 SS=D		F 0692		

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F 0692 SS=D	Continued from page 38 483.25(g)(1)-(3) Nutrition/Hydration Status Maintenance §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by:	F 0692	1. Resident # 67 has Ensure Pudding once daily and ProStat twice daily added to his EMAR to now collect supplement administration and consumption to deter weight loss. 2. The Registered Dietitian completed an audit of current in-house resident supplements ordered to ensure that both supplement administration and consumption are being captured in the medical record. 3. The Clinical Coordinator or designee will re-educate licensed nursing staff and the Registered Dietitian regarding the facility's current Weighing of Residents Policy and the order entry process for supplements to ensure consistent implementation and documentation of physician-ordered nutritional interventions to maintain nutritional parameters and deter weight loss of a resident. 4. The Registered Dietitian or	Completion Date: **03/06/2025** Status: **APPROVED** Date: **02/11/2025**

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F 0692 SS=D	Continued from page 39	F 0692	designee will review current in-house and new resident orders for supplementation weekly for three months to ensure consistent implementation and documentation of physician-ordered nutritional interventions to maintain nutritional parameters and deter weight loss of a resident. Audit results will be reported to the Quality Assurance Performance Improvement committee to determine compliance.	

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F 0692 SS=D	Continued from page 40 Based on a review of clinical records, select facility policy and staff interview it was determined the facility failed to provide documented evidence that interventions for significant weight loss were consistently implemented as planned to promote weight stabilization for one resident (Resident 67) out of seven sampled residents at nutritional risk. Findings include: A review of facility policy entitled "Weighing of Residents", last reviewed by the facility on September 6, 2024, indicated that interventions for undesirable weight loss should focus first on food (e.g., extra food, snacks, calorie-dense food, etc.) based on the resident's current food preferences. Liquid nutritional supplements, per facility formulary, may be considered if resident caloric intake remains inadequate to stabilize or increase weight. Interdisciplinary Team members should consider possible interventions relevant to their discipline. The physician may order tests, appetite stimulants, or medications as appropriate. The suggested	F 0692		

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F 0692 SS=D	Continued from page 41 parameters for evaluating the significance of unplanned and undesired weight loss are as follows; 1 month- 5% weight loss is significant, greater than 5% is severe, 3 months- 7.5% weight loss is significant, greater than 7.5% is severe, and 6 months- 10% weight loss is significant, greater than 10% is severe. A review of the clinical record revealed that Resident 67 was admitted to the facility on September 16, 2024, 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 congestive heart failure (a condition that occurs when the heart can't pump enough blood to the body). The resident's weight upon admission was 207.8 pounds. The resident experienced multiple hospitalizations and was readmitted to the facility on October 11, 2024, and October 19, 2024. A weight record review indicated that on October 20, 2024, the	F 0692		

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F 0692 SS=D	Continued from page 42 resident's weight was 196.4 pounds, reflecting a 5.5% weight loss (11.4 pounds) within one month, meeting the facility's definition of significant weight loss. A review of a nutrition admission/readmission progress notes in the resident's clinical record completed by the facility's Registered Dietitian (RD) dated October 20, 2024, at 7:23 AM, documented the resident's weight loss, attributing it to CHF (congestive heart failure occurs when the heart is unable to pump sufficiently to maintain blood flow to meet the body's needs) , related fluid loss from IV Lasix therapy. The RD adjusted the resident's dietary preferences to include additional high-protein foods but did not update the physician or responsible party at that time. A progress noted completed by the RD on October 31, 2024, at 9:02 AM, noted further weight loss, documenting a weight of 188.6 pounds on October 30, 2024, which represented an 8% weight loss (16.7 pounds from weight of September 16, 2024,	F 0692		

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F 0692 SS=D	Continued from page 43 of 207.8 pounds) within one month. The RD discussed a daily nutritional supplement (Ensure pudding) with the resident, who agreed to consume it, and indicated that nursing staff would update the physician on the weight loss. A subsequent RD progress note on November 2, 2024, at 7:35 AM, indicated the physician was informed of the resident's weight loss, and a care plan was updated to include Ensure pudding daily. On November 7, 2024, the Certified Registered Nurse Practitioner (CRNP) ordered ProStat 30 mL (a high protein oral nutrition supplement), twice daily. Further review of Resident 67's clinical record failed to reveal documented evidence the orders for weight loss interventions, supplement of choice (Ensure pudding) daily or ProStat twice daily, were initiated as planned to manage weight loss. The Medication Administration Record (MAR) did not include records of supplement administration or consumption.	F 0692		

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F 0692 SS=D	Continued from page 44 During an interview on January 24, 2025, at 9:00 AM, the RD stated that licensed nursing staff would be expected to document the consumption of Ensure pudding and ProStat in the MAR. Upon further review, the RD confirmed that neither supplement was documented in the MAR and acknowledged the facility failed to implement the planned nutritional interventions to address the resident's weight loss. Additionally, the RD confirmed the facility failed to consistently implement and document physician-ordered nutritional interventions to maintain nutritional parameters and deter weight loss of a resident. 28 Pa Code 211.10 (a)(c) Resident care policies. 28 Pa Code 211.12 (c)(d)(3)(5) Nursing services.	F 0692		

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F 0698 SS=D		F 0698		

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F 0698 SS=D	Continued from page 46 483.25(l) Dialysis §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive 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 0698	1. For Residents #121 and #187, fanny packs with emergency supplies were placed in the resident room and on their wheelchair per National Kidney Foundation and the facility's Care of the Dialysis Resident Policy/Procedure. 2. The DON assessed current in-house hemodialysis residents on 02/05/2025. Current in-house hemodialysis residents had a fanny pack with emergency supplies located both in the resident room and on the resident wheelchair. 3. The Clinical Coordinator or designee will re-educate licensed facility staff regarding the facility's Care of the Dialysis Resident Policy/Procedure requirement for a fanny pack with emergency supplies to always be available in the resident room and on the resident wheelchair. 4. The DON or designee will continue to review current in-house hemodialysis residents weekly to assure compliance regarding the	Completion Date: **03/06/2025** Status: **APPROVED** Date: **02/11/2025**

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F 0698 SS=D	Continued from page 47	F 0698	facility's Care of the Dialysis Resident Policy/Procedure requirement for a fanny pack with emergency supplies to be always located both in the resident room and on the resident wheelchair. This weekly review will continue for the next three months. Audit results will be reported to the Quality Assurance Performance Improvement committee monthly for three months to assure continued compliance.	

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F 0698 SS=D	Continued from page 48 Based on observation, a review of clinical records, and resident and staff interview, it was determined that the facility failed to ensure the ready availability of necessary emergency supplies for two residents out of three sampled receiving hemodialysis (Residents 121 and 187). Findings include: According to the National Kidney Foundation, patients receiving hemodialysis (a lifesaving treatment for kidney failure that removes waste and extra fluids from the blood and regulates blood pressure) should keep emergency care supplies on hand in case of complications related to their dialysis access site. A review of the facility policy titled "Care of Dialysis Resident" last reviewed by the facility on September 6, 2024, revealed that if a resident has a temporary catheter for dialysis, they are to always have an emergency protocol kit with them. Nurses are required to document in the electronic treatment	F 0698		

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F 0698 SS=D	Continued from page 49 administration record every four hours that the full kit is present with the resident. A review of Resident 121's clinical record revealed the resident was admitted to the facility on April 30, 2024, with diagnoses to include end stage renal disease (final, permanent stage of chronic kidney disease, where the kidneys can no longer function on their own), and dependence on renal dialysis (process of removing waste products and excess fluid from the body when the kidneys are not able to adequately filter the blood). Resident 121's clinical record indicated she was receiving hemodialysis through a right chest double lumen catheter (the dialysis catheter contains two lumens: venous and arterial. Although both lumens are in the vein, the "arterial" lumen, like natural arteries, carries blood away from the heart, while the "venous" lumen returns blood towards the heart. The arterial lumen (typically red) withdraws blood from the patient and carries it to the dialysis machine, while the venous lumen (typically blue)	F 0698		

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F 0698 SS=D	Continued from page 50 returns blood to the patient (from the dialysis machine) for dialysis access every Monday, Wednesday, and Friday. Resident 121's clinical record revealed a physician order dated January 17, 2025, directed the resident must always have a fanny pack (the fanny pack contains the emergency kit), containing an emergency kit in both the resident's room and on the resident's wheelchair. The fanny pack is required to contain a blue clamp, ABD pads (pads designed for high absorbency to manage heavy draining wounds), 4x4 gauze (gauze dressings), and tape, with staff checking its placement every shift. Observations conducted on January 21, 2025, at 11:50 AM, and January 23, 2025, at 10:15 AM, revealed that only one fanny pack was present on the resident's wheelchair. The second fanny pack, required to be in the resident's room, was not present in the resident's room. Interview with Resident 121, a cognitively intact	F 0698		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395103	A. BLDG: __00_____ B. WING: _____	01/24/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
ELAN SKILLED NURSING AND REHAB, A JEWISH SENIOR LIFE COMMUNI	**1101 VINE STREET SCRANTON, PA 18510**
STATE LICENSE NUMBER: **360402**	

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F 0698 SS=D	Continued from page 51 resident, at the time of the observation indicated the only fanny pack she was aware of was the one on the back of her wheelchair. Interview with Employee 4 (licensed practical nurse) at the time of the observation confirmed the absence of the second fanny pack in the resident's room and indicated the fanny pack, containing the emergency supplies, should be readily available in the room and on the resident's wheelchair. Review of Resident 187's clinical record revealed admission to the facility on January 10, 2025, with diagnoses which included chronic obstructive pulmonary disease (COPD a type of obstructive lung disease characterized by long-term poor airflow. The main symptoms include shortness of breath and cough with sputum production. COPD typically worsens over time), diabetes, and dependence on renal dialysis. Review of Resident 187's physician orders revealed a physician order dated January 10, 2025, required	F 0698		

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F 0698 SS=D	Continued from page 52 the resident to have a fanny pack containing an emergency kit in both the resident's room and on the wheelchair, with placement checked every shift. Observations performed on January 21, at approximately 11:00 AM, on January 22, at approximately 10:30 AM, and again on January 23, 2025, at approximately 10:30 AM, revealed the fanny pack was only available on the wheelchair; the second fanny pack was missing from the resident's room. Interview with Employee 1, LPN, on January 23, 2025, at approximately 10:30 AM, confirmed that the second fanny pack containing the emergency supplies was not present in the resident's room as required. Further interview with the Clinical Operations Executive on January 24, 2025, at 1:10 PM, confirmed that residents receiving dialysis should have emergency fanny packs in both their rooms and on their wheelchairs to ensure immediate access	F 0698		

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F 0698 SS=D	Continued from page 53 to emergency supplies in the event of a dialysis-related complication. The facility failed to ensure that emergency dialysis supplies were readily available as ordered for Residents 121 and 187, as evidenced by missing emergency fanny packs in their rooms. This failure placed the residents at risk for delayed emergency intervention in the event of complications related to their dialysis access sites. The facility did not ensure compliance with physician orders or its own policy, which requires staff to verify the presence of emergency supplies every shift. 28 Pa. Code 211.12 (d)(3)(5) Nursing services	F 0698		
F 0756 SS=E		F 0756		

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F 0756 SS=E	Continued from page 54 483.45(c)(1)(2)(4)(5) Drug Regimen Review, Report Irregular, Act On §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record.	F 0756	1. The facility cannot correct the untimely action to justify the prescribing of two antidepressants, however, Resident #114 has an active Gradual Dose Reduction (GDR) in place since 02/03/25 to discontinue his Venlafaxine, removing the antidepressant duplicate therapy. The facility cannot correct the delay in the physician response to pharmacist recommendation. Medication was discontinued on 01/08/2025. Resident #130 has documented clinical rationale for the continuation of Zyprexa as ordered. 2. The DON completed an audit of in-house residents presently on duplicate antidepressant medications on 02/07/2025. Listing reviewed with consulting pharmacist. Consulting pharmacist to issue medication regimen reviews to the appropriate physician to document the clinical rationale justifying the continued prescribing of duplicate antidepressant	Completion Date: **03/06/2025** Status: **APPROVED** Date: **02/11/2025**

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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F 0756 SS=E	Continued from page 55 §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by:	F 0756	medication. 3. The DON or designee will re-educate the consulting pharmacist, attending physicians and medical directors to Tag F 0756 and CMS 483.45(c)(1)(2)(4)(5) requirements, along with the facility's Monthly Medication Regimen Review Policy. 4. The DON or designee will review the monthly medication reviews sent to Elan Skilled by the consulting pharmacist and compare them to the listing of new residents receiving duplicate antidepressant therapy to ensure compliance with CMS 483.45(c)(1)(2)(4)(5) and facility policy. This review will take place for the next three months. Audit results will be reported to the Quality Assurance Performance Improvement committee to determine compliance.	

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F 0756 SS=E	Continued from page 56 Based on a review of clinical records and staff interview, it was determined the consultant pharmacist failed to identify drug irregularities (dual anti-depressant therapy and justification for antipsychotic medication) when completing monthly medication reviews and the facility failed to assure that resident's attending physician timely acted upon pharmacist identified irregularities in the medication regimen for two residents out of five residents sampled for unnecessary medications (Residents 114 and 130). Findings included: Review of Resident 114's clinical record revealed the resident was admitted to the facility on June 6, 2024, with diagnoses to include dementia with behavioral disturbances (is a general term that describes the deterioration of memory, language, and other thinking abilities and can be accompanied by behavioral and psychological symptoms such as agitation, anxiety, and psychosis) and major depressive disorder (a mood disorder that causes a	F 0756		

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F 0756 SS=E	Continued from page 57 persistent feeling of sadness and loss of interest that affects how one feels, thinks, and behaves and can lead to a variety of emotional and physical problems). A review of the resident's physician's order dated June 6, 2024, 8:30 PM, revealed an order for Venlafaxine HCL Extended Release 24 Hour (an antidepressant) 75 mg (milligrams), give one capsule by mouth one time a day related to unspecified depression. Additionally, a review physician's orders dated June 7, 2024, at 9:30 AM, revealed the attending physician increased the resident's dose of Venlafaxine HCl ER Tablet Extended Release 24 Hour 75 MG, to give 2 tablets (150 mg) by mouth one time a day related to unspecified depression. A review of nursing progress notes in Resident 114's clinical record revealed a "Change in Condition" note completed by Employee 3, Licensed Practical Nurse (LPN), dated July 12,	F 0756		

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F 0756 SS=E	Continued from page 58 2024, at 11:09 AM, revealed a change in condition assessment was completed related to the resident's attending physician increasing the Venlafaxine related to increased depression. A review of the resident's physician's order dated July 14, 2024, 8:00 PM, revealed an order for Venlafaxine HCL Extended Release 24 Hour 75 mg, give 2 capsules by mouth twice per day at bedtime related to unspecified depression. A review of a Psychiatric Assessment progress note completed by the facility's consultant Psychiatric Mental Health Nurse Practitioner (PMHNP) dated September 25, 2024, at 11:38 AM, revealed Resident 114's mood has deteriorated since last visit (September 18, 2024) and resident agitated and confrontational to other residents. His mood had been deteriorating since before the death of his wife, and only stands to continue to be exacerbated by the grieving process. Furthermore, his poor cognition limits his ability to go through the normal grieving process. Recommend antidepressant	F 0756		

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F 0756 SS=E	Continued from page 59 coverage at this time and plan to start Mirtazapine (an antidepressant used to treat depression) 7. 5mg orally at bedtime for depression and continue Venlafaxine 75 mg by mouth in the morning for depression and Venlafaxine 150mg by mouth at bedtime for depression. Further review of physician's orders dated September 27, 2024, at 8:30 PM, revealed an order for Mirtazapine oral tablet (an antidepressant used to treat depression) 7.5 mg, give 1 tablet by mouth in the evening for as ordered related to diagnosis of unspecified depression. Despite the presence of duplicate antidepressant therapy (Venlafaxine and Mirtazapine), a review of the consultant pharmacist's medication regimen reviews failed to identify this irregularity. The resident's clinical record lacked documentation of pharmacist recommendations to assess the appropriateness of duplicate therapy or a documented clinical rationale justifying the prescribing of two antidepressants.	F 0756		

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F 0756 SS=E	Continued from page 60 A review of Resident 130's clinical record revealed the resident was admitted to the facility on August 30, 2024, with diagnoses to include dementia with severe agitation (a person is restless and worried, and unable able to settle down with behaviors that may include pacing, not be able to sleep, or act aggressively toward others) and depression. A review of physician's orders dated August 30, 2024, at 8:30 PM, revealed an order for Olanzapine Oral Tablet 2.5 mg (atypical antipsychotic), for dementia with agitation. CMS regulations require that a clinical rationale or diagnosis must support the use of antipsychotic medications, yet the consultant pharmacist's new admission medication review on September 4, 2024, failed to identify a lack of documented justification for the continued use of Olanzapine. A review of physician's orders in Resident 130's clinical record dated August 30, 2024, at 8:30 AM, revealed orders for Aricept (used to manage	F 0756		

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F 0756 SS=E	Continued from page 61 dementia and can help improve attention, memory, behavior, and ability to do daily activities) 10 mg, give 1 tablet daily at bedtime related to dementia. Further review of physician's orders revealed an order dated August 31, 2024, at 8:00 AM, for Aricept 5 mg, give 1 tablet by mouth one time a day for dementia. A review of the facility's consultant pharmacist's new admission medication regime review (MMR) dated September 4, 2024, identified the resident had a current order for Aricept and that there were two active orders for 10 mg and 5 mg without specification stating the total dose of 15 mg. Optimal timing for Aricept was to be given at bedtime and indicated the physician's order had 10 mg at bedtime and 5 mg in the morning and requested for the physician to review. The consultant pharmacist identified this discrepancy but failed to ensure timely physician action, as the resident continued receiving the medication as	F 0756		

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F 0756 SS=E	Continued from page 62 prescribed without clarification or modification through January 8, 2025. Further review of the clinical record failed to reveal that the resident's attending physician timely addressed the consultant pharmacist new admission medication regime review (MMR) that was completed on September 4, 2024, related to prescribing practices for Aricept. An interview with the Director of Nursing (DON) on January 24, 2025, at 10:15 AM, confirmed the consultant pharmacist failed to identify and address medication regimen irregularities for Residents 114 and 130. The DON also confirmed Resident 130's attending physician failed to timely act upon the pharmacist's recommendations and did not provide a documented clinical rationale for the continued use of antipsychotic medication.. 28 Pa. Code 211.9 (k) Pharmacy services. 28 Pa. Code 211.12 (c) Nursing services.	F 0756		

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 0756 SS=E	Continued from page 63 28 Pa. Code 211.2 (d)(3) Medical Director.	F 0756		
F 0791 SS=D	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	F 0791	1. Resident 88 was referred to in-house dental services. 2. All residents have the potential to be affected by deficient practice. Director of Nursing will audit all residents to identify any resident who may not have had dental services. 3. Social Services will be educated regarding the Dental Services Policy and Procedures. 4. All residents are offered dental services upon admission. All residents without dental services in the previous 12 months will be offered dental services. All residents will be scheduled for dental services per policy and procedure. Social Services or designee will audit Dental services monthly until substantial compliance is achieved. All results will be submitted and reviewed in QAPI.	Completion Date: **03/06/2025** Status: **APPROVED** Date: **02/07/2025**

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F 0791 SS=D	Continued from page 64 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; §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		

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 65 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 88) out of four residents sampled for dental services. Findings include: Review of Resident 88's clinical record revealed admission to the facility on March 24, 2021, and the resident's payor source was Medicaid. There was no documented evidence at the time of the survey ending January 24, 2025, the resident had been offered dental services in the past year. Interview with the Clinical Operations Executive on January 23, 2025, at 1:57 PM confirmed the facility had not offered Resident 88 routine dental services in the past year. 28 Pa. Code 211.12 (c)(d)(3)(5) Nursing services	F 0791		

Certified End Page

ELAN SKILLED NURSING AND REHAB, A JEWISH SENIOR LIFE COMMUNI

STATE LICENSE NUMBER: 360402

SURVEY EXIT DATE: 01/24/2025

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

Jeanne Parisi
Deputy Secretary for Quality Assurance

Debra L. Bogen MD

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Secretary of Health

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