STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395298	A. BLDG: 00 B. WING:	04/02/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
LAKEWOOD REHABILITATION & HEALTHCARE CENTER STATE LICENSE NUMBER: **191502**	**147 OLD NEWPORT ST** **NANTICOKE, PA 18634**

(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 an abbreviated complaint survey completed on April 2, 2025, it was determined that Lakewood Rehabilitation and Healthcare Center 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 0610 SS=D		F 0610		

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 0610 SS=D	Continued from page 1 483.12(c)(2)-(4) Investigate/Prevent/Correct Alleged Violation §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by:	F 0610	1. Resident CR1 has discharged from the facility. 2. Current residents have been interviewed. No residents report any knowledge of Resident CR1 behavior, sexual gratification, on the identified date. No residents or staff report an allegation of abuse related to resident R #1 behavior, on the identified date. 3. Facility staff will be re-educated by the NHA and or designee to the facility policy for abuse reporting and investigation to rule out potential resident abuse. 4. The Inter Disciplinary Team will audit resident progress notes, daily as part of the facility Clinical meeting process, to identify any instances of resident behavior requiring initiation of abuse reporting and investigation. If an allegation of abuse is identified NHA and DON will follow abuse investigation policy. All abuse investigations will be submitted to and reviewed by the facility QAPI Committee.	Completion Date: **04/15/2025** Status: **APPROVED** Date: **04/16/2025**

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F 0610 SS=D	Continued from page 2 Based on a review of select facility policy, clinical records, information submitted by the facility, select investigative reports, and staff interviews, it was determined the facility failed to conduct a thorough investigation into allegations of potential resident-to-resident abuse for one resident out of 12 sampled (Resident 2) perpetrated by another resident (Resident CR1). Findings include: A review of facility policy titled "Abuse, Neglect, Exploitation, and Misappropriation Prevention Program," last reviewed by the facility on July 21, 2024, revealed it is the facility policy that residents have the right to be free from abuse, neglect, and exploitation. The policy indicates this includes but is not limited to freedom from corporal punishment, involuntary seclusion, and verbal, mental, sexual, or physical abuse. The policy indicates the abuse prevention program consists of a facility-wide commitment to protect residents from abuse, neglect, and exploitation by anyone, including other	F 0610		

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F 0610 SS=D	Continued from page 3 residents. Further review of the facility policy revealed the facility will develop and implement policies and protocols to prevent and identify abuse or mistreatment of residents and identify and investigate all possible incidents of abuse, neglect, and mistreatment. A clinical record review revealed Resident 2 was admitted to the facility on February 28, 2024, with diagnoses that include dementia (a condition characterized by the loss of cognitive functioning, such as thinking, remembering, and reasoning, to such an extent that it interferes with a person's daily life and activities). A review of an annual Minimum Data Set assessment (MDS-a federally mandated standardized assessment process conducted periodically to plan resident care) dated February 7, 2025, revealed that Resident 2 is severely cognitively impaired with a BIMS score of 00 (Brief	F 0610		

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F 0610 SS=D	Continued from page 4 Interview for Mental Status- a tool within the Cognitive Section of the MDS that is used to assess the resident's attention, orientation, and ability to register and recall new information; a score of 00-07 indicates severe cognitive impairment). A clinical record review revealed Resident CR1 was admitted to the facility on June 23, 2023, with diagnoses that include hemiplegia (paralysis on one side of the body) and cerebral infarction (brain damage that results from a lack of blood). Further clinical record review revealed a Pennsylvania State Police Megan's Law Public Report dated June 20, 2023, which identified Resident CR1 as having a history of a sexual offense conviction(s) record in the Pennsylvania Sexual Offender Registry (the Pennsylvania Sex Offender Registry, established under Megan's Law, is a public database managed by the Pennsylvania State Police that lists individuals convicted of certain sexual offenses, with the aim of protecting communities by making this information accessible). The document	F 0610		

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F 0610 SS=D	Continued from page 5 indicated Resident CR1 has a sexual offense conviction for involuntary deviate sexual intercourse (involuntary deviate sexual intercourse in Pennsylvania law involves engaging in oral, anal, or object penetration with another person without their voluntary consent due to force, threat of force, unconsciousness, unawareness, impairment by drugs or alcohol, mental disability, or the age difference in certain non-marital situations) on May 12, 2006. The care plan for Resident CR1, initiated on August 8, 2023, identified a focus area that the resident was a registered sex offender. The goal was for the resident to display no evidence of sexual advances toward staff or visitors. Interventions implemented to support this goal included providing non-judgmental support, offering psychological or psychiatric services as needed, and ensuring that no staff or visitors under the age of 18 entered Resident CR1's room unless accompanied by an adult. Additionally, the care plan dated August 8, 2023, identified that Resident CR1 exhibited inappropriate	F 0610		

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F 0610 SS=D	Continued from page 6 sexual behaviors toward staff and residents, including exposing his genitals in public areas and masturbating in hallways. The goal was for the resident to display no evidence of behavior problems through the next review period. Interventions in place to assist the resident in meeting this goal included 1:1 supervision while awake, 15-minute safety checks while asleep, staff using calm approaches, redirecting and distracting the resident during behavioral episodes, providing non-judgmental support, and documenting all episodes of inappropriate behavior. A review of a quarterly MDS assessment dated February 1, 2025, revealed that Resident CR1 is cognitively intact with a BIMS score of 13 (a score of 13-15 indicates cognition is intact). A progress note dated January 27, 2025, at 5:43 AM, revealed Resident CR1 to remain on 1:1 watch while awake and out of bed and 15-minute checks when the resident is in bed sleeping secondary to allegations of inappropriate touching of another	F 0610		

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F 0610 SS=D	Continued from page 7 resident on January 17, 2025. A progress note dated February 22, 2025, at 9:27 PM revealed Resident CR1 was noted by staff earlier today to be masturbating while out of bed in the room doorway within direct view of staff and other residents. The resident was redirected and informed that the behavior was unacceptable. The note indicated that these behaviors continued for a few minutes as staff walked across the hall to dispose of trash or get soiled laundry in proper receptacles. Documentation showed that on February 22, 2025, at 9:27 PM Resident CR1 was observed earlier masturbating in the doorway of his room, while out of bed, which is across the hall from Resident 2's room, visible to staff and other residents. This behavior persisted for a few minutes, despite redirection as staff walked across the hall to dispose of trash or get soiled laundry in proper receptacles. A progress note dated February 23, 2025, at 1:06	F 0610		

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F 0610 SS=D	Continued from page 8 PM revealed Employee 2, social services director, was made aware Resident CR1 was seen masturbating in the hall. The note indicated Employee 2, the social services director, explained to Resident CR1 the behavior is not acceptable in the hall. Employee 2 explained that Resident CR1 would need to masturbate in the privacy of his room. Resident CR1's care plan was updated to include offering resident redirection to room for self-sexual gratification with privacy sign in place initiated on February 27, 2025. A progress note dated March 17, 2025, at 5:59 PM indicated Resident CR1 was discharged into the custody of his parole officer. During an interview on April 2, 2025, at 10:05 AM, Employee 2, the social services director, indicated she met with Resident CR1 on February 23, 2025, to provide education regarding his inappropriate behaviors, such as exposing himself and	F 0610		

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F 0610 SS=D	Continued from page 9 masturbating. Employee 2, the social services director, indicated she was unaware of any other residents who were involved in the incident that occurred on February 22, 2025. During an interview on April 2, 2025, at approximately 2:24 PM, Employee 1, Licensed Practical Nurse (LPN), indicated Resident CR1 was standing in his bedroom doorway masturbating on February 22, 2025. Employee 1, LPN, recalled another staff member yelling, "Pick your pants up." However, Employee 1 was not able to remember the other staff member's name. She explained Resident CR1 masturbated while looking at Resident 2 in her bedroom. Employee 1, LPN, indicated she redirected Resident CR1 from his doorway into his room and told him that behavior is not acceptable. Employee 1, LPN, indicated Resident 2 was unable to describe the event due to her cognitive status. During the interview on April 2, 2025, Employee 1,	F 0610		

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F 0610 SS=D	Continued from page 10 LPN, indicated she reported that Resident CR1 was masturbating in view of other residents in report and documented the information in Resident CR1's clinical record. Employee 1, LPN, explained the facility never asked her for more information regarding the incident. Employee 1, LPN, indicated that she believed the Nursing Home Administrator (NHA) was informed about the incident but did not indicate that she personally informed the NHA. A review of the facility floor plan revealed Resident CR1's room was across the hall from Resident 2's room at the time of the alleged incident. During an interview on April 2, 2025, at approximately 1:30 PM, the Nursing Home Administrator (NHA) confirmed there was no documented evidence the facility investigated the allegations that Resident CR1 masturbated in view of other residents, including Resident 2. Although Resident 2 was unable to describe the event due to her cognitive impairment and the facility	F 0610		

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F 0610 SS=D	Continued from page 11 could not determine whether she perceived or was emotionally affected by the incident the nature of the behavior warranted a thorough investigation. The NHA confirmed it is the facility's responsibility to conduct a thorough investigation into allegations of abuse to ensure all residents are protected from abuse. 28 Pa. Code 201.14 (a) Responsibility of licensee 28 Pa. Code 201.18(e)(1) Management 28 Pa. Code 201.29(a) Resident Rights 28 Pa. Code 211.12(c) Nursing Services	F 0610		

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P 5520	Nursing services. (3) Effective July 1, 2024, a minimum of 1 nurse aide per 10 residents during the day, 1 nurse aide per 11 residents during the evening, and 1 nurse aide per 15 residents overnight. This REGULATION is not met as evidenced by:	P 5520	1. The facility cannot retroactively correct nurse aide staffing ratio. 2.NHA/designee will conduct an initial audit of the past two weeks' schedule to determine if nurse aide ratio is in compliance. 3. NHA/designee will re-educate the scheduler on the proper nurse aide staffing ratios. The facility will hold labor meetings Monday-Friday to verify ratios are made. 4. NHA/designee will conduct random audits of nurse aide staffing weekly for four weeks, then monthly for two months thereafter to verify proper nurse aide ratios. Results of audits will be reviewed by the Quality Assurance Performance Improvement Committee and changes will be made as necessary.	Completion Date: **04/15/2025** Status: **APPROVED** Date: **04/14/2025**

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

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P 5520	Continued from page 1 Based on a review of nurse aide staffing and staff interview, it was determined that the facility failed to ensure the minimum nurse aide staff to resident ratio was provided on each shift for three 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 the minimum nurse aide staff of 1:10 on the day shift, 1: 11 on the evening shift, and 1:15 on the night shift based on the facility's census. March 27, 2025 - 5.63 nurse aides on the night shift versus the required 6.47 for a census of 97. March 29, 2025- 5.00 nurse aides on the night sift versus the required 6.20 for a census of 93. March 30, 2025- 3.63 nurse aides on the night shift versus the required 6.13 for a census of 92. On the above dates mentioned no additional excess higher-level staff were available to compensate this	P 5520		

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P 5520	Continued from page 2 deficiency. An interview with the Nursing Home Administrator on April 2, 2025, at approximately 1:30PM confirmed the facility failed to consistently provide minimum nurse aide staffinh hours to each resident on the above metioned shifts.	P 5520		
P 5640		P 5640		

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P 5640	Continued from page 3 Nursing services. (2) Effective July 1, 2024, the total number of hours of general nursing care provided in each 24-hour period shall, when totaled for the entire facility, be a minimum of 3.2 hours of direct resident care for each resident. This REGULATION is not met as evidenced by:	P 5640	1. The facility cannot retroactively correct staffing PPD. 2. NHA/designee will conduct an initial audit of the past two weeks scheduled to determine if PPD are in compliance. 3.NHA /designee will re-educate the scheduler on the proper PPD. The facility will hold labor meetings Monday-Friday to verify PPD is made. 4. NHA/designee will conduct random audits of facility PPD weekly for four weeks, then monthly for two months thereafter to verify proper PPD hours. Results of audits will be reviewed by the Quality Assurance Performance Improvement Committee and changes will be made as necessary.	Completion Date: **04/15/2025** Status: **APPROVED** Date: **04/14/2025**

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LAKEWOOD REHABILITATION & HEALTHCARE CENTER STATE LICENSE NUMBER: **191502**	**147 OLD NEWPORT ST NANTICOKE, PA 18634**

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P 5640	Continued from page 4 Based on a review of nurse staffing, resident census, and staff interview, it was determined that the facility failed to consistently provide the minimum nursing care hours to each resident daily for two of seven days reviewed. Findings include: A review of the facility's weekly staffing records revealed that on the following dates the facility failed to provide the minimum nurse staffing of 3.20 hours of general nursing care to each resident. March 28, 2025- 3.14 direct care nursing hours per resident. March 30, 2025- 3.02 direct care nursing hours per resident. The facility's general nursing hours were below the minimum required ratio on the dates noted above. An interview with the Nursing Home Administrator on April 2, 2025, at approximately 1:30PM	P 5640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395298	A. BLDG: __00_____ B. WING: _____	04/02/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
LAKEWOOD REHABILITATION & HEALTHCARE CENTER STATE LICENSE NUMBER: **191502**	**147 OLD NEWPORT ST NANTICOKE, PA 18634**

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P 5640	Continued from page 5 confirmed the facility failed to consistently provide minimum general nursing care hours to each resident daily.	P 5640		

Certified End Page

LAKEWOOD REHABILITATION & HEALTHCARE CENTER

STATE LICENSE NUMBER: 191502

SURVEY EXIT DATE: 04/02/2025

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