

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395357	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/10/2025
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NAME OF PROVIDER OR SUPPLIER: ELLEN MEMORIAL HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE: 23 ELLEN MEMORIAL LANE HONESDALE, PA 18431
STATE LICENSE NUMBER: 318502	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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	F 0000		
F 0656 SS=D	Based on a Medicare/Medicaid Recertification, State Licensure, Civil Rights Compliance Survey and Abbrievted Complaint Survey completed on January 10, 2025, it was determined that Ellen Memorial Health Care 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 0656		

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 0656 SS=D	Continued from page 1 483.21(b)(1)(3) Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv) In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future	F 0656	0656 1. Resident 67's comprehensive care plan has been updated to reflect the POLST, MD orders, progress notes and resident/representative instructions. 2. Residents POLST forms have been reviewed for conformity with MD orders, progress notes and resident /representative instructions. The care plans have the appropriate interventions and goals to meet their individual needs. 3. Facility procedures for developing comprehensive care plans have been reviewed/ revised to assure MD orders, progress notes and resident/representative instructions represented on the POLST are included on the comprehensive care plan. The procedures have been in-serviced to the care planning team. 4. The NHA/designee will audit 5 random charts per week to assure MD orders, progress notes and resident/representative instructions represented on the POLST are included on the comprehensive care	Completion Date: 02/18/2025 Status: APPROVED Date: 01/21/2025

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F 0656 SS=D	Continued from page 2 discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by:	F 0656	plan. The audit will be turned in to the QA team for review. 5. February 18, 2025	

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F 0656 SS=D	Continued from page 3 Based on review of clinical records and staff interview it was determined the facility failed to fully develop and revise a person-centered comprehensive care plan to meet the individualized needs of one resident out of 20 sampled (Resident 67). Findings included: A review of Resident 67's clinical record revealed the resident was admitted to the facility on July 26, 2021, with diagnoses that included Alzheimer's disease (a brain disorder that slowly destroys memory and thinking skills and, eventually, the ability to carry out the simplest tasks) and muscle weakness. A review of Resident 67's POLST (Pennsylvania Orders for Life Sustaining Treatment, a process that helps an individual receive the medical treatment they want, and avoid the medical treatments they do not want, when they are seriously ill or frail) initiated by the facility's Social Worker (SW) and completed	F 0656		

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F 0656 SS=D	Continued from page 4 with Resident 67's RP (responsible party) dated September 5, 2024, indicated the resident's code status was changed to do-not-resuscitate (DNR a medical order written by a doctor. It instructs health care providers not to do cardiopulmonary resuscitation (CPR) if breathing stops or if the heart stops beating and comfort care (a specialized patient care approach focused on managing symptoms, relieving pain, and enhancing quality of life. It is typically offered to residents who have experienced multiple hospitalizations, where further medical interventions are unlikely to change the outcome), elected medical interventions for comfort measures, antibiotic use to be determined when infection occurs or with comfort as the goal, and no hydration or nutrition by means of a feeding tube. The POLST form dated September 5, 2024, and a progress note by the Social Worker indicated that the resident's responsible party (RP) had elected a care plan that included do-not-resuscitate (DNR), comfort care, antibiotics for comfort, and no artificial hydration or nutrition by tube.	F 0656		

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F 0656 SS=D	Continued from page 5 Physician's orders dated September 5, 2025, at 1:15 PM, revealed that the Resident 67's code status was DNR. A review of the resident's comprehensive plan of care, last revised on September 15, 2024, failed to reflect these updated medical treatment goals and interventions. Despite updated physician orders and documentation in progress notes, the care plan did not address the resident's goals for comfort measures only, the selective use of antibiotics, or the decision to forego artificial hydration and nutrition. On January 10, 2025, the Social Worker confirmed that the resident's RP elected comfort measures due to the resident's progressive weight loss and variable meal intake. The Director of Nursing (DON) confirmed that the facility failed to revise the resident's care plan to include the specific medical treatment goals outlined	F 0656		

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F 0656 SS=D	Continued from page 6 by the POLST form and RP's instructions. The facility failed to incorporate the resident's medical treatment goals for comfort measures only, antibiotics use for comfort, and no hydration or artificial nutrition by tube.. 28 Pa. Code 211.12 (d)(5) Nursing services	F 0656		
F 0690 SS=D		F 0690		

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F 0690 SS=D	Continued from page 7 483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2) For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.	F 0690	0690 1. Resident 65 has started a bowel/bladder diary to evaluate continence and provide a proper training program for bowel/bladder habits. Results of the program have been placed on the cardex and put on the comprehensive care plan. 2. Residents who are identified as having the potential to improve their continence will be placed on a retraining program. Residents will be assessed upon admission, readmission quarterly and annually. 3. The Bowel and bladder policy has been reviewed/ revised to assure residents who are identified as having the potential to improve continence are placed on a retraining program. The policy has been in-serviced to licensed and direct care staff. 4. The DON/designee will audit 5 residents (admits, readmits, sig change, annual) to assure that residents that have the potential to improve continence are placed on a retraining program. The audit will be turned in to the QA team for review.	Completion Date: 02/18/2025 Status: APPROVED Date: 01/21/2025

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F 0690 SS=D	Continued from page 8 This REQUIREMENT is not met as evidenced by:	F 0690	5. February 18, 2025	
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F 0690 SS=D	Continued from page 9 Based on a review of clinical records, and staff interview, it was determined the facility failed to implement individualized approaches to prevent declines in bowel continency and restore normal bowel function to the extent possible for one resident (Resident 65) out of 20 residents sampled. Findings include: Review of facility policy entitled "Bladder and Continence", last reviewed on January 2, 2025, indicated residents who are identified as having the potential to improve continence, place on a retraining program. According to the policy, upon admission, re-admission, with any significant change, and after urinary catheter removal, a bowel and bladder diary will be completed for a minimum of three days to gather information about the resident's current continence status. Upon review of the data gathered from the diary, a continence evaluation will be completed, and an appropriate toileting program implemented.	F 0690		

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F 0690 SS=D	<p>Continued from page 10</p> <p>A review of Resident 65's clinical record revealed admission to the facility on February 23, 2024, with diagnoses which included hypertension (high blood pressure), anxiety, and recurrent urinary tract infections.</p> <p>A review of Resident 65's admission Minimum Data Set assessment (MDS- a federally mandated standardized assessment process conducted periodically to plan resident care) dated March 1, 2024, section H, bowel, and bladder, indicated the resident was frequently incontinent of bladder and frequently incontinent of bowel and was not on a toileting program to manage the resident's incontinence. The resident required partial/moderate assistance (helper does less than half the effort, helper lifts, holds, or supports trunk or limbs, but provides less than half the effort) with activities of daily living which included toilet transfer and toileting hygiene.</p> <p>A review of Resident 65's care plan-initiated February 26, 2024, revealed that the resident has an</p>	F 0690		

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F 0690 SS=D	Continued from page 11 ADL self-care performance deficit related to weakness and need for assist with personal care. There was no evidence the facility had evaluated the resident's bowel and/or bladder habits and status to develop an individualized toileting retraining program to decrease episodes of incontinence. A Continence Evaluation completed on April 9, 2024, indicated that Resident 65 experienced occasional incontinence of both bowel and bladder. Recommendations included routine toileting before and after meals, at bedtime, and as requested, with checks and changes every three hours during the night. Despite this evaluation, there was no evidence that the recommended program was implemented. 28 Pa. Code 211.12 (d)(5) Nursing services.	F 0690		
F 0849 SS=D		F 0849		

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F 0849 SS=D	Continued from page 12 483.70(n)(1)-(4) Hospice Services §483.70(n) Hospice services. §483.70(n)(1) A long-term care (LTC) facility may do either of the following: (i) Arrange for the provision of hospice services through an agreement with one or more Medicare-certified hospices. (ii) Not arrange for the provision of hospice services at the facility through an agreement with a Medicare-certified hospice and assist the resident in transferring to a facility that will arrange for the provision of hospice services when a resident requests a transfer. §483.70(n)(2) If hospice care is furnished in an LTC facility through an agreement as specified in paragraph (o)(1)(i) of this section with a hospice, the LTC facility must meet the following requirements: (i) Ensure that the hospice services meet professional standards and principles that apply to individuals providing services in the facility, and to the timeliness of the services. (ii) Have a written agreement with the hospice that is signed by an authorized representative of the hospice and an authorized representative of the LTC facility before hospice care is furnished to any resident. The written agreement must set out at least the following: (A) The services the hospice will provide. (B) The hospice's responsibilities for determining the appropriate hospice plan of care as specified in §418.112 (d) of this chapter.	F 0849	0849 1. Comprehensive care plans for Residents 69 and 7 have been revised so that the facility and hospice care plans are integrated to meet the resident's care needs. 2. Residents/Representatives electing the hospice benefit will have care plans integrated with hospice to meet the resident's care needs. 3. The coordination of hospice service policy has been reviewed/revised to assure that care and service between the facility and Hospice Agency is integrated. PCC will be contacted for care plan information to better our electronic care planning. The policy will be in-serviced to the IDT. 4. The NHA/designee will audit residents on hospice weekly to assure hospice and facility care plans are integrated and promote to meet the resident's care needs. 5. February 18, 2025	Completion Date: 02/18/2025 Status: APPROVED Date: 01/21/2025

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F 0849 SS=D	Continued from page 13 (C) The services the LTC facility will continue to provide based on each resident's plan of care. (D) A communication process, including how the communication will be documented between the LTC facility and the hospice provider, to ensure that the needs of the resident are addressed and met 24 hours per day. (E) A provision that the LTC facility immediately notifies the hospice about the following: (1) A significant change in the resident's physical, mental, social, or emotional status. (2) Clinical complications that suggest a need to alter the plan of care. (3) A need to transfer the resident from the facility for any condition. (4) The resident's death. (F) A provision stating that the hospice assumes responsibility for determining the appropriate course of hospice care, including the determination to change the level of services provided. (G) An agreement that it is the LTC facility's responsibility to furnish 24-hour room and board care, meet the resident's personal care and nursing needs in coordination with the hospice representative, and ensure that the level of care provided is appropriately based on the individual resident's needs. (H) A delineation of the hospice's responsibilities, including but not limited to, providing medical direction and management of the patient; nursing; counseling (including spiritual, dietary, and bereavement); social work; providing medical supplies, durable medical equipment, and	F 0849		

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F 0849 SS=D	Continued from page 14 drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related conditions; and all other hospice services that are necessary for the care of the resident's terminal illness and related conditions. (I) A provision that when the LTC facility personnel are responsible for the administration of prescribed therapies, including those therapies determined appropriate by the hospice and delineated in the hospice plan of care, the LTC facility personnel may administer the therapies where permitted by State law and as specified by the LTC facility. (J) A provision stating that the LTC facility must report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by hospice personnel, to the hospice administrator immediately when the LTC facility becomes aware of the alleged violation. (K) A delineation of the responsibilities of the hospice and the LTC facility to provide bereavement services to LTC facility staff. §483.70(n)(3) Each LTC facility arranging for the provision of hospice care under a written agreement must designate a member of the facility's interdisciplinary team who is responsible for working with hospice representatives to coordinate care to the resident provided by the LTC facility staff and hospice staff. The interdisciplinary team member must have a clinical background, function within their State scope of practice act, and have the ability to assess the resident or have access to someone that has the skills and	F 0849		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395357	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/10/2025	
NAME OF PROVIDER OR SUPPLIER: ELLEN MEMORIAL HEALTH CARE CENTER STATE LICENSE NUMBER: 318502		STREET ADDRESS, CITY, STATE, ZIP CODE: 23 ELLEN MEMORIAL LANE HONESDALE, PA 18431		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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 0849 SS=D	Continued from page 15 capabilities to assess the resident. The designated interdisciplinary team member is responsible for the following: (i) Collaborating with hospice representatives and coordinating LTC facility staff participation in the hospice care planning process for those residents receiving these services. (ii) Communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the patient and family. (iii) Ensuring that the LTC facility communicates with the hospice medical director, the patient's attending physician, and other practitioners participating in the provision of care to the patient as needed to coordinate the hospice care with the medical care provided by other physicians. (iv) Obtaining the following information from the hospice: (A) The most recent hospice plan of care specific to each patient. (B) Hospice election form. (C) Physician certification and recertification of the terminal illness specific to each patient. (D) Names and contact information for hospice personnel involved in hospice care of each patient. (E) Instructions on how to access the hospice's 24-hour on-call system. (F) Hospice medication information specific to each patient. (G) Hospice physician and attending physician (if any)	F 0849		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395357	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/10/2025	
NAME OF PROVIDER OR SUPPLIER: ELLEN MEMORIAL HEALTH CARE CENTER STATE LICENSE NUMBER: 318502		STREET ADDRESS, CITY, STATE, ZIP CODE: 23 ELLEN MEMORIAL LANE HONESDALE, PA 18431		
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F 0849 SS=D	Continued from page 16 orders specific to each patient. (v) Ensuring that the LTC facility staff provides orientation in the policies and procedures of the facility, including patient rights, appropriate forms, and record keeping requirements, to hospice staff furnishing care to LTC residents. §483.70(n)(4) Each LTC facility providing hospice care under a written agreement must ensure that each resident's written plan of care includes both the most recent hospice plan of care and a description of the services furnished by the LTC facility to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, as required at §483.24. This REQUIREMENT is not met as evidenced by:	F 0849		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395357	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/10/2025	
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F 0849 SS=D	Continued from page 17 Based on a review of clinical records and staff interview, it was determined the facility failed to ensure coordination of care and services between the facility and the Hospice Agency for two residents (Residents 69 and 7). Findings include: A review of Resident 69's clinical record revealed the resident was admitted to the facility on October 30, 2024, with diagnoses to include dementia (a chronic or persistent disorder of the mental processes caused by brain disease or injury and marked by memory disorders, personality changes, and impaired reasoning) and Alzheimer's disease (a progressive disease that destroys memory and other important mental functions). A review of physician's order dated December 4, 2024, revealed the resident was admitted into hospice services for a diagnosis of end stage Alzheimer's disease.	F 0849		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395357	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/10/2025	
NAME OF PROVIDER OR SUPPLIER: ELLEN MEMORIAL HEALTH CARE CENTER STATE LICENSE NUMBER: 318502		STREET ADDRESS, CITY, STATE, ZIP CODE: 23 ELLEN MEMORIAL LANE HONESDALE, PA 18431		
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F 0849 SS=D	<p>Continued from page 18</p> <p>A review of the resident's care plan initially dated October 30, 2024, and last revised November 25, 2024, revealed the resident's care plan failed to reflect coordination of services between the facility and the Hospice agency in meeting the resident's daily care needs and specific needs related to care and services provided for the resident's terminal diagnosis.</p> <p>A review of Resident 7's clinical record revealed she was admitted to the facility on September 19, 2024, with diagnoses to include dementia (a chronic or persistent disorder of the mental processes caused by brain disease or injury and marked by memory disorders, personality changes, and impaired reasoning).</p> <p>A review of physician's order dated September 19, 2024, revealed the resident was admitted into hospice services for a diagnosis of end stage dementia.</p> <p>A review of the resident's care plan initially dated</p>	F 0849		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395357	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/10/2025	
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F 0849 SS=D	Continued from page 19 September 19, 2024, and last revised December 10, 2024, revealed the resident's care plan failed to reflect coordination of services between the facility and the Hospice agency in meeting the resident's daily care needs and specific needs related to care and services provided for the resident's terminal diagnosis. An interview with the director of nursing on January 8, 2025, at approximately 12:30 pm, confirmed the resident's care plan was not coordinated with hospice services. 28 Pa. Code 211.12 (c)(d)(1)(3)(5) Nursing services 28 Pa. Code 201.21(c) Use of outside resources	F 0849		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395357	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/10/2025
NAME OF PROVIDER OR SUPPLIER: ELLEN MEMORIAL HEALTH CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: 23 ELLEN MEMORIAL LANE HONESDALE, PA 18431		
STATE LICENSE NUMBER: 318502				
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P 5520	<p>Nursing services.</p> <p>(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.</p> <p>This REGULATION is not met as evidenced by:</p>	P 5520	<p>5520</p> <ol style="list-style-type: none"> The facility cannot retroactively correct nurse aide staffing ratios for the past. The facility will review nurse aide ratios daily to provide care according to Pennsylvania regulation on staffing. (1-10; 1-11; 1-15) Regulations for nurse aide ratios have been reviewed facility management. Facility management will project ratios daily to have staff set according to guidelines. Nursing will track ratios daily and provide a copy of the numbers to the administrator. The numbers will be provided to the QA team to track compliance. February 18, 2025 	<p>Completion Date: 02/18/2025</p> <p>Status: APPROVED</p> <p>Date: 01/21/2025</p>
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE:		(X6) DATE:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395357	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/10/2025
NAME OF PROVIDER OR SUPPLIER: ELLEN MEMORIAL HEALTH CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: 23 ELLEN MEMORIAL LANE HONESDALE, PA 18431		
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P 5520	Continued from page 1 Based on a review of nurse staffing and staff interview, it was determined the facility failed to ensure the minimum nurse aide staff to resident ratio was provided on each shift for 13 shifts out of 63 reviewed. Findings include: A review of the facility's weekly staffing records revealed that on the following dates the facility failed to provide 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. October 17, 2024 - 6.87 nurse aides on the night shift, versus the required 6.93 for a census of 104. October 18, 2024 - 6.80 nurse aides on the evening shift, versus the required 9.64 for a census of 106. October 21, 2024 - 8.20 nurse aides on the evening shift, versus the required 9.45 for a census of 104. October 22, 2024 - 8.93 nurse aides on the evening shift, versus the required 9.27 for a census of 102. November 19, 2024 - 8.40 nurse aides on the	P 5520		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395357	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/10/2025
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P 5520	Continued from page 2 evening shift, versus the required 9.45 for a census of 104. November 21, 2024 - 6.00 nurse aides on the night shift, versus the required 6.93 for a census of 104. November 23, 2024 - 8.93 nurse aides on the evening shift, versus the required 9.45 for a census of 104. November 23, 2024 - 5.80 nurse aides on the night shift, versus the required 6.93 for a census of 104. December 30, 2024 - 9.00 nurse aides on the evening shift, versus the required 9.18 for a census of 101. December 31, 2024 - 8.53 nurse aides on the evening shift, versus the required 9.09 for a census of 100. December 31, 2024 - 5.43 nurse aides on the night shift, versus the required 6.67 for a census of 100. January 2, 2025 - 7.73 nurse aides on the evening shift, versus the required 9.27 for a census of 102. January 2, 2025 - 6.47 nurse aides on the night shift, versus the required 6.87 for a census of 102. On the above dates mentioned, no additional excess	P 5520		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395357	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/10/2025
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P 5520	Continued from page 3 higher-level staff were available to compensate this deficiency. An interview with the Nursing Home Administrator on January 9, 2025, at approximately 2:00 PM, confirmed the facility had not met the required nurse aide to resident ratios on the above dates.	P 5520		
P 5530		P 5530		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395357	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/10/2025
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P 5530	Continued from page 4 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	5530 1. The facility cannot retroactively correct LPN staffing ratios for the past. 2. The facility will review LPN ratios daily to provide care according to Pennsylvania regulation on staffing. (1-25; 1-25; 1-40) 3. Regulations for LPN ratios have been reviewed by facility management. Facility management will project ratios daily to have staff set according to guidelines. 4. Nursing will track LPN ratios daily and provide a copy of the numbers to the administrator. The numbers will be provided to the QA team to track compliance. 5. February 18, 2025	Completion Date: 02/18/2025 Status: APPROVED Date: 01/21/2025

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P 5530	Continued from page 5 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 13 shifts out of 63 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. October 17, 2024 - 4.00 LPNs on the day shift, versus the required 4.16 for a census of 104. October 19, 2024 - 4.00 LPNs on the day shift, versus the required 4.24 for a census of 106. October 20, 2024 - 3.75 LPNs on the day shift, versus the required 4.20 for a census of 105. October 22, 2024 - 4.00 LPNs on the day shift, versus the required 4.16 for a census of 104. November 19, 2024 - 4.00 LPNs on the day shift,	P 5530		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395357	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/10/2025
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P 5530	Continued from page 6 versus the required 4.12 for a census of 103. November 22, 2024 - 3.00 LPNs on the evening shift, versus the required 3.47 for a census of 104. November 23, 2024 - 4.00 LPNs on the day shift, versus the required 4.16 for a census of 104. November 24, 2024 - 4.00 LPNs on the day shift, versus the required 4.16 for a census of 104. November 25, 2024 - 4.00 LPNs on the day shift, versus the required 4.20 for a census of 105. January 02, 2025 - 3.38 LPNs on the day shift, versus the required 4.04 for a census of 101. January 02, 2025 - 2.56 LPNs on the night shift, versus the required 2.58 for a census of 103. January 04, 2025 - 3.50 LPNs on the day shift, versus the required 4.04 for a census of 101. January 05, 2025 - 4.00 LPNs on the day shift, versus the required 4.04 for a census of 101. On the above dates mentioned, no additional excess higher-level staff were available to compensate this deficiency. An interview with the Nursing Home Administrator	P 5530		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395357	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/10/2025
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P 5530	Continued from page 7 on January 9, 2025, at approximately 12:00 PM, confirmed the facility had not met the required LPN to resident ratios on the above dates.	P 5530		
P 5640	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	5640 1. The facility cannot retroactively correct nursing PPDs for the past. 2. The facility will review nursing PPD daily to provide care according to Pennsylvania regulation on staffing (3.20 hours) 3. Regulations for nursing PPD have been reviewed facility management. Facility management will project PPD daily to have staff set according to guidelines. 4. Nursing will track PPD daily and provide a copy of the numbers to the administrator. The numbers will be provided to the QA team to track compliance. 5. February 18, 2025	Completion Date: 02/18/2025 Status: APPROVED Date: 01/21/2025

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P 5640	Continued from page 8 Based on a review of nurse staffing, state regulation, and staff interview, it was determined the facility failed to consistently provide minimum general nursing care hours to each resident daily. Findings include: A review of the facility's staffing levels revealed on the following dates the facility failed to provide minimum nurse staffing of 3.20 hours of general nursing care to each resident: October 18, 2024 - 3.02 direct care nursing hours per resident. October 20, 2024 - 3.02 direct care nursing hours per resident. October 21, 2024 - 3.05 direct care nursing hours per resident. October 23, 2024 - 3.17 direct care nursing hours per resident. November 22, 2024 - 3.03 direct care nursing hours per resident. November 23, 2024 - 2.90 direct care nursing	P 5640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395357	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/10/2025
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P 5640	Continued from page 9 hours per resident. November 24, 2024 - 3.16 direct care nursing hours per resident. January 1, 2025 - 3.15 direct care nursing hours per resident. January 2, 2025 - 3.10 direct care nursing hours per resident. January 4, 2025 - 3.04 direct care nursing hours per resident. January 5, 2025 - 3.08 direct care nursing hours per resident. The facility's general nursing hours were below minimum required levels on the dates noted above. An interview with the Nursing Home Administrator on January 9, 2025, at approximately 2:00 PM, confirmed the facility failed to consistently provide minimum general nursing care hours to each resident daily.	P 5640		



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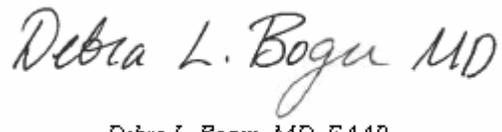
ELLEN MEMORIAL HEALTH CARE CENTER

STATE LICENSE NUMBER: 318502

SURVEY EXIT DATE: 01/10/2025

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, 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