| 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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| | 395493 | A. BLDG: 00<br>B. WING: | 08/15/2025 |

| NAME OF PROVIDER OR SUPPLIER: | STREET ADDRESS, CITY, STATE, ZIP CODE: |
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| **JULIA RIBAUDO EXTENDED CARE CENTER**<br>STATE LICENSE NUMBER: **101802** | **1404 GOLF PARK DRIVE PO BOX 97**<br>**LAKE ARIEL, PA 18436** |

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| F 0000 | INITIAL COMMENT<br><br>Based on a Medicare/Medicaid Recertification, State Licensure, Civil Rights Compliance survey, and Abbreviated Complaint survey completed on August 15, 2025, it was determined that Julia Ribaudo Extended Care Facility was not in compliance with the following requirements of 42 Part 483 Subpart B Requirements for Long-Term Care Facilities and the 28 PA Code Commonwealth of Pennsylvania Long Term Care Licensure Regulations. | F 0000 | | |
| F 0550<br><br>SS=E | | F 0550 | | |

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 0550<br><br>SS=E | Continued from page 1<br><br>483.10(a)(1)(2)(b)(1)(2) Resident Rights/Exercise of Rights<br><br>§483.10(a) Resident Rights.<br>The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section.<br><br>§483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.<br><br>§483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.<br><br>§483.10(b) Exercise of Rights.<br>The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.<br><br>§483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. | F 0550 | Preparation, submission and implementation of the Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed as a means to continuously improve the quality of care and to comply with state and federal regulatory requirements<br><br>The facility is unable to retroactively correct Resident 3 and Resident 29's personal space being impeded on by wandering resident's 16 and 19. All residents who voiced concerns during resident council meeting were offered interventions that will deter wandering residents from entering their rooms.<br><br>To identify like resident's that could be affected by wandering resident's the DON/designee will interview all current alert and oriented residents with BIMS of 12 and greater.<br>To prevent reoccurrence the NHA/designee will educate the IDT | Completion Date: **09/12/2025**<br>Status: **APPROVED**<br>Date: **09/03/2025** |

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| F 0550<br><br>SS=E | Continued from page 2<br><br>§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.<br><br>This REQUIREMENT is not met as evidenced by: | F 0550 | team completing concierge rounds to follow up with the identified alert and oriented residents to monitor any further concerns or resolution.<br>To prevent reoccurrence nursing staff re-educated on the redirection of wandering residents to prevent the wandering of residents into peer's rooms<br>To monitor and maintain compliance DON/designee will interview 6 random alert and oriented residents with BIMS of 12 and greater to monitor resolution of wandering residents weekly x4 and then monthly x2. Results will be reviewed at QAPI | |
| | | | | |

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| F 0550<br><br>SS=E | Continued from page 3<br><br>Based on a review of clinical records, resident council meeting minutes, and resident and staff interviews, it was determined the facility failed to provide an environment that promotes each resident's quality of life by ensuring residents' personal space was free from intrusions by other residents (Residents 16 and 19), including experiences reported by two residents out of the 25 residents sampled (Residents 3 and 29) and experiences reported by six out of the eight residents during a resident group interview (Residents 26, 28, 32, 49, 69, and 90).<br><br>Findings include:<br>A review of resident council meeting minutes dated May 27, 2025, revealed residents in attendance had concerns regarding one resident wandering into resident rooms. A review of the meeting minutes failed to determine if this concern was resolved.<br><br>A review of resident council meeting minutes dated June 26, 2025, revealed residents in attendance had concerns regarding wandering residents. The minutes indicated the concerns for wandering residents were better. A review of the meeting minutes failed to determine if this concern was resolved.<br><br>A review of resident council meeting minutes dated July 29, 2025, revealed residents in attendance had concerns | F 0550 | | |

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| F 0550<br><br>SS=E | Continued from page 4<br><br>regarding wandering residents. The meeting minutes indicated the issue of wandering residents is better; however, it was indicated that one resident continues to wander through resident room doorways. Further review of the meeting minutes failed to determine if this concern was resolved or if any further actions were taken to resolve the issue.<br><br>A clinical record review revealed Resident 3 was admitted to the facility on July 12, 2025, with diagnoses that included chronic obstructive pulmonary disease (COPD is a condition caused by damage to the airways or other parts of the lung that blocks airflow and makes it hard to breathe).<br><br>A review of an admission Minimum Data Set assessment (MDS a federally mandated standardized assessment process conducted periodically to plan resident care) dated July 13, 2025, revealed that Resident 3 was cognitively intact with a BIMS score of 13 (Brief 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 1315 indicates cognition is intact).<br><br>A clinical record review revealed Resident 29 was admitted to the facility on October 7, 2020, with diagnoses that included diabetes (a chronic disease that occurs either when the pancreas does not produce enough insulin or | F 0550 | | |

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| F 0550<br><br>SS=E | Continued from page 5<br><br>when the body cannot effectively use the insulin it produces).<br><br>A review of a quarterly Minimum Data Set assessment (MDS) dated August 5, 2025, revealed that Resident 29 was moderately cognitively impaired with a BIMS score of 12 a score of 08-12 indicates cognition is moderately impaired.<br><br>A clinical record review revealed Resident 16 was admitted to the facility on May 9, 2024, with diagnoses that included 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).<br><br>A review of a significant change in status Minimum Data Set assessment (MDS) dated July 22, 2025, revealed that Resident 16 is severely cognitively impaired with a BIMS score of 4 a score of 00-07 indicates cognition is severely impaired.<br><br>A clinical record review revealed Resident 19 was admitted to the facility on December 8, 2022, with diagnoses that included dementia. A review of a significant change in status Minimum Data Set assessment (MDS)dated May 19, 2025, Section C100 Cognitive Patterns, revealed Resident 19 had short-term and long-term memory problems, inattention, and severe cognitive impairment to make | F 0550 | | |

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| F 0550<br><br>SS=E | Continued from page 6<br><br>decisions.<br><br>During an interview on August 12, 2025, at 9:55 AM, Resident 29 explained that she is upset because Resident 16 continues to enter her room uninvited. She indicated that Resident 16 wanders into her room, rummages through her belongings, and has eaten her snacks. Resident 29 explained this has been an ongoing issue, and she has reported it to the facility, but Resident 16 continues to enter her room uninvited. Resident 29 indicated she has to hide her food so Resident 16 doesnt wander in and steal it.<br><br>During an interview on August 12, 2025, at 10:05 AM, Resident 3 explained she is frustrated because Resident 16 continues to enter her room uninvited. She indicated Resident 16 wanders into her room, sits on her bed, and has tried to pull the covers off of her bed. Resident 3 explained that she is angry and does not want Resident 16 in her room. She indicated she has to yell for staff to have the resident removed from her room.<br><br>During a resident council interview on August 13, 2025, at 10:00 AM, six out of eight residents reported ongoing concerns with resident(s) wandering into their rooms (Residents 26, 28, 32, 49, 69, and 90). The six residents described ongoing concerns with intrusions from multiple residents, including Residents 16 and 19. The residents in attendance explained they have informed the facility about these issues over the last several weeks, but residents | F 0550 | | |

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| F 0550<br><br>SS=E | Continued from page 7<br><br>wandering into their rooms remains a problem for them at the facility.<br><br>During an interview on August 14, 2025, at approximately 1:30 PM, the Nursing Home Administrator (NHA) and Director of Nursing (DON) confirmed resident wandering has been a concern residents have expressed during resident council meetings. The NHA indicated residents have expressed fewer episodes of resident intrusions into other residents rooms but confirmed resident wandering has been an ongoing focus for the facility.<br><br>28 Pa. Code 201.18(e)(1) Management.<br><br>28 Pa. Code 201.29 (a) Resident rights.<br><br>28 Pa. Code 211.12 (d)(3) Nursing services. | F 0550 | | |
| F 0584<br><br>SS=E | | F 0584 | | |

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| F 0584<br><br>SS=E | Continued from page 8<br><br>483.10(i)(1)-(7) Safe/Clean/Comfortable/Homelike Environment<br><br>§483.10(i) Safe Environment.<br>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.<br><br>The facility must provide-<br>§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.<br>(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.<br>(ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.<br><br>§483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;<br><br>§483.10(i)(3) Clean bed and bath linens that are in good condition;<br><br>§483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);<br><br>§483.10(i)(5) Adequate and comfortable lighting levels in all | F 0584 | The facility is unable to retroactively correct the available linen supply on E Hallway and A Hallway linen cart.<br><br>This has the ability to affect all residents NHA/Designee completed audit of all linen carts and rooms to ensure there was available linens.<br><br>To prevent reoccurrence the NHA/designee will educate housekeeping/laundry aides and CNAs on facility linen laundering processes and location of clean linen should the linen cart need to be restocked.<br><br>To monitor and maintain compliance the NHA/designee will ensure adequate supply of linens is available in linen carts and supply closets weekly x 4 and monthly x 2. Results will be reviewed at QAPI. | Completion Date: **09/12/2025**<br>Status: **APPROVED**<br>Date: **09/03/2025** |

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| F 0584<br><br>SS=E | Continued from page 9<br><br>areas;<br><br>§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<br><br>§483.10(i)(7) For the maintenance of comfortable sound levels.<br><br>This REQUIREMENT is not met as evidenced by: | F 0584 | | |

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| F 0584<br><br>SS=E | Continued from page 10<br><br>Based on resident council meeting minutes, resident and staff interviews, and observations it was determined the facility failed to maintain an adequate supply of clean linens to meet the needs of residents for 2 of 4 resident care units observed (E Hallway and A Hallway).<br><br>Finding include:<br><br>Review of the Resident Council meeting minutes dated July 29, 2025, revealed residents expressed concerns regarding the availability of linens. The minutes further documented that the Nursing Home Administrator identified nurse aides were discarding washcloths, and the Administrator noted that a lot of linen had been ordered for staff to utilize while providing care to residents.<br><br>Observations conducted on August 12, 2025, at approximately 11:00 AM in the E Hallway revealed one washcloth available for resident care. Additional observation of the A Hallway at approximately 11:15 AM on the same day revealed a linen cart containing only three bath towels and three washcloths available for resident care.<br><br>Observations conducted on August 13, 2025, at 8:15 AM in the E Hallway revealed no washcloths and only four bath towels available for resident care. On August 14, 2025, at 10:00 AM, observation of the A Hallway revealed only two bath towels and two washcloths available for resident | F 0584 | | |

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| F 0584<br><br>SS=E | Continued from page 11<br><br>care.<br><br>An interview conducted with Employee 10 (Nurse Aide) on August 14, 2025, revealed the staff frequently experienced difficulty finding clean washcloths and towels. The staff member reported that clean linens were not delivered to the floor until after 9:00 AM, despite care being provided prior to that time, resulting in a shortage of available linens.<br><br>Observation conducted on August 14, 2025, at approximately 11:00 AM of the facility laundry room revealed no additional linens available for staff use. Further observation of the linen closet located outside the E Hallway revealed 12 washcloths and 10 bath towels in storage.<br><br>An interview with the Nursing Home Administrator on August 14, 2025, at approximately 1:00 PM revealed the facility had previously identified an issue with linens being sent out to be laundered and not returned. The Administrator was unable to provide further information to confirm that the facility maintained an adequate number of linens to meet residents daily needs.<br><br>28 Pa. Code 211.12 (c)(d)(1)(5) Nursing services.<br><br>28 Pa. Code 205.74 Linen | F 0584 | | |

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| F 0656<br><br>SS=D | 483.21(b)(1)(3) Develop/Implement Comprehensive Care Plan<br><br>§483.21(b) Comprehensive Care Plans<br>§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 -<br>(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<br>(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).<br>(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.<br>(iv)In consultation with the resident and the resident's representative(s)-<br>(A) The resident's goals for admission and desired outcomes.<br>(B) The resident's preference and potential for future 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 | F 0656 | Resident 22's Transfer Care Plan was updated with individualized needs on.<br><br>To identify like residents a facility audit was completed by DON/designee to identify any residents using a stand lift that have associated anxiety or behaviors and care plans updated to reflect individualized preferences for alternative safe transfers, other than facility policy to utilize hoyer lift,<br>To prevent reoccurrence the DON/designee will educate licensed nursing on updating resident care plans with individualized preferences as they occur.<br><br>To monitor and maintain compliance DON/designee will audit residents with new orders for stand lift/hoyer lift, with associated anxiety or behaviors requiring individualized needs related to transfers and update care plans as needed weekly x 4 and monthly x 2. Results will be reviewed at QAPI. | Completion Date: **09/12/2025**<br>Status: **APPROVED**<br>Date: **09/02/2025** |

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| | 395493 | A. BLDG: __00_____ B. WING: _____ | 08/15/2025 |

| NAME OF PROVIDER OR SUPPLIER: | STREET ADDRESS, CITY, STATE, ZIP CODE: |
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| **JULIA RIBAUDO EXTENDED CARE CENTER** STATE LICENSE NUMBER: **101802** | **1404 GOLF PARK DRIVE PO BOX 97 LAKE ARIEL, PA 18436** |

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| F 0656<br><br>SS=D | Continued from page 13<br><br>entities, for this purpose.<br>(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.<br>§483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-<br>(iii) Be culturally-competent and trauma-informed.<br><br>This REQUIREMENT is not met as evidenced by: | F 0656 | | |

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| F 0656<br><br>SS=D | Continued from page 14<br><br>Based on clinical record review, staff interviews, and resident interviews, it was determined the facility failed to develop and implement a comprehensive, person-centered care plan that addressed the residents individualized needs and interventions for safe transfers for one out of 25 residents sampled (Resident 22).<br><br>Findings include:<br><br>A clinical record review revealed Resident 22 was admitted to the facility on January 14, 2025, with diagnoses that included chronic kidney disease (gradual loss of kidney function) and anxiety disorder (a condition in which excessive worry causes clinically significant distress or impairment in social, occupational, or other areas of functioning).<br><br>A physicians order indicated Resident 22 required the assistance of two staff members for transfers using the standing lift (mechanical device used to help a resident who has some weight bearing ability but cannot safely stand or transfer without assistance) initiated on January 14, 2025.<br><br>A review of a quarterly Minimum Data Set assessment (MDS a federally mandated standardized assessment process conducted periodically to plan resident care) dated | F 0656 | | |

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| F 0656<br><br>SS=D | Continued from page 15<br><br>May 23, 2025, revealed that Resident 22 is moderately cognitively impaired with a BIMS score of 08 (Brief 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 0812 indicates moderate cognitive impairment).<br><br>A progress note dated August 11, 2025, at 10:45 PM documented that Resident 22 bit a nurse aide during a transfer to bed performed by two staff members. The note indicated Resident 22 stated, Yes, I bit you, and that the nursing supervisor was informed of the incident.<br>During an interview on August 13, 2025, at 9:30 AM, Resident 22 explained she was upset by the way she was transferred to bed earlier this week. Resident 22 indicated that two staff manually transferred her to bed without the use of the standing lift as normally performed, which frightened her and caused distress.<br><br>Following inquiries conducted during the survey week, Resident 22s care plan was updated on August 14, 2025, to include that she experienced severe anxiety regarding transfers with the standing lift. The updated intervention specified the standing lift as the primary transfer method; however, staff could use a manual two-person assist, when necessary, due to the residents anxiety or behavioral responses. | F 0656 | | |

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| F 0656<br><br>SS=D | Continued from page 16<br><br>During an interview on August 14, 2025, at 9:25 AM, Employee 2, Director of Rehabilitation Services, confirmed that the standing lift with two staff was the ordered method for Resident 22s transfers and that staff were expected to follow physician orders and the individualized plan of care. Employee 2 indicated the care plan was updated on August 14, 2025, after learning of Resident 22s anxiety during transfers.<br><br>During an interview on August 14, 2025, at 11:35 AM, Employee 3, Nurse Aide (NA), stated that on August 11, 2025, at approximately 9:45 PM, she and Employee 4, NA, manually transferred Resident 22 into bed. Employee 3 indicated Resident 22 became anxious and bit her during the transfer. Employee 3 reported this incident to the therapy department on August 12, 2025. Employee 4, NA, was not available for interview on August 14, 2025.<br><br>During an interview on August 14, 2025, at approximately 2:00 PM, the above findings were reviewed with the Nursing Home Administrator (NHA) and Director of Nursing (DON). Through this review, it was established that staff are expected to follow physician orders and implement each residents individualized plan of care. It was further confirmed during the review that Resident 22s plan | F 0656 | | |

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| F 0656<br><br>SS=D | Continued from page 17<br><br>of care did not identify her anxiety regarding transfers, nor did it include the option for a manual two-person assist until updates were made on August 14, 2025, following surveyor inquiries.<br><br>28 Pa Code 211.10 (c) Resident care policies.<br>28 Pa Code 211.12 (d)(1)(3) Nursing services. | F 0656 | | |
| F 0689<br><br>SS=D | | F 0689 | | |

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| F 0689<br><br>SS=D | Continued from page 18<br><br>483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices<br><br>§483.25(d) Accidents.<br>The facility must ensure that -<br>§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and<br><br>§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.<br><br>This REQUIREMENT is not met as evidenced by: | F 0689 | Resident 62's POC was reviewed, CRNP was notified of Pepto Bismol at bedside. New orders received for Pepto Bismol and self-administration assessment completed. Trellegy inhaler removed from resident room and explained that there was no current order without incident. Resident 62 has an order in place from 10/10/2024 that she may keep combivent inhaler at bedside and self-administer.<br>Resident instructed to keep medications in locked bedside table. Initial audit performed to ensure that no other residents had medications at bedside and if so, medications were removed and if indicated self-assessment were completed. Resident 63 was immediately educated on facility policy for visitor entry. Facility staff immediately educated on visitor entry policy and keeping the entry behind the desk restricted if staff not present. Maintenance director applied plastic casing with lock over unlocking mechanism. | Completion Date: **09/12/2025** Status: **APPROVED** Date: **09/04/2025** |

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| F 0689<br><br>SS=D | Continued from page 19 | F 0689 | To identify like resident that could be affected resident's DON/designee will interview residents with a BIMS of 12 or higher to ask if they would like to self-administer and if they request same a self-administration assessment will be completed. All residents assessed and determined to self-administer will be educated on keeping medications locked at bedside.<br>To identify like residents that could be affected all residents that are alert and oriented with a BIMS of 12 and above that are independently mobile were educated on the visitor entry policy.<br><br>To prevent reoccurrence DON/designee will educate licensed nurses on the self-administration policy.<br>To prevent reoccurrence DON/designee will educate all facility staff were educated on visitor entry policy and keeping the entry behind desk restricted if staff not present. | |

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| F 0689<br><br>SS=D | Continued from page 20 | F 0689 | To monitor and maintain compliance DON/designee will audit all new residents with a BIMS of 12 or higher for self-administration preferences and self-administration assessments weekly x 4 weeks and monthly x 2 months. To monitor and maintain compliance DON/designee will audit that medications are not left out and available for other residents to get.<br>To monitor and maintain compliance DON/designee will audit front desk to ensure resident access behind the desk is restricted if employee not present behind the desk and that access to entry mechanism is not accessible if staff is not present behind the desk weekly x 4 and monthly x 2. Results will be reviewed at QAPI | |
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| F 0689<br><br>SS=D | Continued from page 21<br><br>Based on observations, a review of clinical records, documentation provided by the facility, and resident and staff interviews, it was determined that the facility failed to implement adequate safety measures to prevent accidents for two out of 25 residents sampled (Resident 62 and 63).<br><br>Findings include:<br><br>A review of facility policy titled "Self-Administration of Medications," last revised June 2024, revealed the interdisciplinary team should assess and determine with respect to each resident whether self-administration of medications is safe and clinically appropriate, based on the residents functionality and health condition. The policy indicates that if it is deemed safe and appropriate for a resident to self-administer medications, this is documented in the medical record and the care plan, the facility should routinely assess the residents cognitive, physical and visual ability to carry out this responsibility, and the resident should have a locked medication storage compartment in their room so that another resident is not is not able to access the medications.<br><br>A clinical record review revealed Resident 62 was admitted to the facility on September 12,2024, with diagnoses which included Chronic Obstructive Pulmonary Disease (a disease that restricts airflow to the lungs and causes breathing problems). | F 0689 | | |

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| F 0689<br><br>SS=D | Continued from page 22<br><br>A quarterly Minimum Data Set Assessment (MDS - a federally mandated standardized assessment conducted at specific intervals to plan resident care) dated April 19, 2025, revealed that Resident 62 was cognitively intact with a BIMS score of 15 (Brief Interview for Mental Status a tool to assess the resident's attention, orientation, and ability to register and recall new information, a score of 13-15 equates to being cognitively intact).<br><br>A review of the clinical record revealed a document labeled Self-Administration of Medications dated for December 15,2024, indicated the resident did not want to self-administer medications.<br><br>During an observation on August 12, 2025, at 11:15AM, in Resident 62s room, a bottle of Pepto Bismol (over the counter antacid/antidiarrheal medication) was noted in a basket on the residents bedside. During an interview with the resident during this observation, the resident stated her nephew usually brings her snacks, and adult briefs and other things she needs. She stated the Pepto Bismol was brought in by her nephew.<br><br>During an interview on August 13,2025, at 12:00 PM with Resident 62, the resident opened her bedside table drawer, and two inhalers were noted to be inside the drawer: A Trelegy Ellipta inhaler (prescription therapy inhaler for long term maintenance of COPD) with the date of 6-22 written on | F 0689 | | |

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| F 0689<br><br>SS=D | Continued from page 23<br><br>it, as well as a Combivent inhaler (prescription inhaler for COPD) with no date observed to be on it.<br><br>During the interview the resident stated that the drawer does not lock, and she keeps them there in the event she becomes short of breath. When asked how the resident obtained the inhalers, she stated, one of the nurses gave them to me. She was unable to recall which nurse provided her the inhalers, nor was she able to recall how long she had them in the bedside table drawer. During this interview, the basket with the bottle of Pepto Bismol was noted to be on the residents bed.<br><br>An interview was conducted on August 14, 2025, at approximately 2:00 PM with the Nursing Home Administrator (NHA) and the Director of Nursing (DON) to discuss the above findings related to the facilitys failure to maintain the residents' environment free of potential accident hazards by leaving medications accessible to residents at their bedside which allows accidental consumption to other residents.<br><br>A clinical record review revealed Resident 63 was admitted to the facility on August 24, 2008, with diagnoses that include Parkinsons disease (a brain disorder that causes unintended or uncontrollable movements, such as shaking, stiffness, and difficulty with balance and coordination). | F 0689 | | |

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| F 0689<br><br>SS=D | Continued from page 24<br><br>A review of a quarterly Minimum Data Set assessment (MDS) dated July 14, 2025, revealed that Resident 63 has moderate cognitive impairment with a BIMS score of 10; a score of 08-12 indicates cognition is moderately impaired.<br><br>A review of Resident 63s care plan revealed he has a problem with noncompliance related to refusal to participate in restorative programs, refusal of medication, and attempts to go behind the front desk and push a button to allow visitors or staff to enter the building, initiated on July 1, 2025. Interventions implemented, including a gate, will be used to prevent entry behind the front desk when not attended by staff, and Resident 63 will be provided with education related to compliance and negative outcomes related to noncompliance.<br><br>An observation on August 12, 2025, at approximately 8:15 AM revealed Resident 63 behind the front desk. Resident 63 pressed and activated the mechanism to allow the survey team to gain entrance to the facility. Upon entering the facility, Resident 63 indicated to the survey team not to tell anyone, because he is not allowed to go behind the | F 0689 | | |

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| F 0689<br><br>SS=D | Continued from page 25<br><br>front desk.<br><br>During an interview on August 12, 2025, at approximately 11:00 AM, the Nursing Home Administrator (NHA) confirmed the facility failed to ensure adequate safety measures were in place to prevent possible accidents. The NHA confirmed the facility failed to ensure adequate safety measures were implemented to prevent Resident 63 from gaining access to the area behind the front desk.<br><br>A follow-up observation on August 12, 2025, at approximately 2:30 PM revealed a plastic lock covering installed at the front desk preventing access to the door unlocking mechanism.<br><br>28 Pa Code 201.18(b)(1) Management.<br><br>28 Pa Code 211.10 (d) Resident care policies.<br><br>28 Pa Code 211.12 (d)(3)(5) Nursing services. | F 0689 | | |
| F 0695<br><br>SS=D | | F 0695 | | |

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| **JULIA RIBAUDO EXTENDED CARE CENTER**<br>STATE LICENSE NUMBER: **101802** | **1404 GOLF PARK DRIVE PO BOX 97 LAKE ARIEL, PA 18436** |

| (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 |
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| F 0695<br><br>SS=D | Continued from page 26<br><br>483.25(i) Respiratory/Tracheostomy Care and Suctioning<br><br>§ 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning.<br>The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart.<br><br>This REQUIREMENT is not met as evidenced by: | F 0695 | Resident #3 concentrator fixed, and humidifier bottle and tubing replaced. Resident #62 concentrator fixed, oxygen bag replaced and dated per policy, humidifier bottle and oxygen tubing replaced<br><br>To identify like residents that have the potential to be affected DON/designee audited residents receiving oxygen therapy to ensure concentrator working properly, humidification bottle not on floor, and documentation present in the electronic clinical record.<br><br>To prevent this from recurring licensed staff will be educated on the oxygen administration policy by the DON/designee.<br><br>To monitor and maintain ongoing compliance DON/designee will audit 5 residents weekly x4 then monthly x2 to ensure concentrator working properly, humidification bottle changed, tubing changed and documented in the | Completion Date: **09/12/2025** Status: **APPROVED** Date: **09/02/2025** |

| 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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| NAME OF PROVIDER OR SUPPLIER: | STREET ADDRESS, CITY, STATE, ZIP CODE: |
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| **JULIA RIBAUDO EXTENDED CARE CENTER** STATE LICENSE NUMBER: **101802** | **1404 GOLF PARK DRIVE PO BOX 97 LAKE ARIEL, PA 18436** |

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| F 0695<br><br>SS=D | Continued from page 27 | F 0695 | electronic record. Result to QAPI for recommendation and follow-up. | |

| 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 0695<br><br>SS=D | Continued from page 28<br><br>Based on a review of clinical records, facility policy, observations, and staff and resident interviews, it was determined the facility failed to ensure oxygen therapy was administered and maintained in accordance with physician orders and facility policy, including requirements for equipment labeling, dating, and routine maintenance, in a manner that minimized the risk for infection for two residents out of twenty-five sampled (Residents 3 and 62).<br><br>Findings include:<br><br>A review of the facility policy titled Oxygen Administration Policy, last reviewed by the facility on February 1, 2025, revealed it is the facilitys policy that licensed clinicians with demonstrated competence will administer oxygen by way of the specified route as ordered by a provider. The policy indicates changing the humidifier bottle (containers attached to an oxygen concentrator to add moisture to the oxygen being delivered) when empty; length of use is dependent upon the liter flow setting (a measurement describing the amount of oxygen delivered in liters per minute, abbreviated as L/min).<br><br>A clinical record review revealed Resident 3 was admitted to the facility on July 12, 2025, with diagnoses that included chronic obstructive pulmonary disease (COPD is a condition caused by damage to the airways or other parts | F 0695 | | |

| 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 0695<br><br>SS=D | Continued from page 29<br><br>of the lungs that blocks airflow and makes it hard to breathe).<br><br>A physicians order dated July 12, 2025, directed staff to administer oxygen (O2) via nasal cannula (a thin tube delivering oxygen through the nostrils) continuously at 3 liters per minute (3 L/min), with humidification added for comfort if needed. Staff were further directed to check the oxygen concentrator for proper function, verify oxygen saturation (the amount of oxygen in the blood), and maintain humidification as appropriate. Additional orders instructed staff to clean the oxygen concentrator and filter, wipe down equipment, air-dry the filter, and change tubing weekly (every seven days).<br><br>An observation on August 12, 2025, at 10:01 AM, revealed Resident 3 was in her bedroom receiving oxygen by way of the nasal cannula. The plastic oxygen humidification bottle was observed sitting directly on the floor (storing medical equipment on the floor creates a risk of contamination because the floor surface cannot be considered a clean or sanitary area for equipment that delivers oxygen directly to a resident) with a clear plastic bag next to it. The humidification bottle and tubing were not dated. The humidification bottle appeared empty.<br><br>A follow-up observation on August 13, 2025, at approximately 9:30 AM, revealed Resident 3 was in her bedroom receiving oxygen by way of the nasal cannula. | F 0695 | | |

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| F 0695<br><br>SS=D | Continued from page 30<br><br>The plastic oxygen humidification bottle was attached to the oxygen concentrator. The humidification bottle and tubing were still not dated and empty.<br><br>An interview conducted with Employee 1, Registered Nurse (RN), at 9:30 AM on August 13, 2025, confirmed the humidification bottle and tubing for Resident 3 were not dated and the bottle was empty.<br><br>A review of Resident 62s clinical record revealed the resident was admitted to the facility on September 12,2024, with diagnoses which included Chronic Obstructive Pulmonary Disease (COPD).<br><br>A physicians order dated August 12, 2025, directed staff to administer oxygen at 2 L/min via nasal cannula continuously, adding humidification if oxygen exceeded 4 L/min or for comfort if needed. Staff were also instructed to clean the concentrator, change the tubing weekly, and clean the filter.<br><br>An observation August 12,2025, at approximately 11:15 AM revealed a clear plastic bag attached to the oxygen concentrator with 7/23 (date) written on it. The bag appeared intended to store the nasal cannula when not in use; however, the nasal cannula and oxygen tubing were observed laying across the length of the bed with the nasal cannula on the floor. The oxygen humidification bottle was observed sitting on the floor with the attachment straps | F 0695 | | |

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| JULIA RIBAUDO EXTENDED CARE CENTER<br>STATE LICENSE NUMBER: 101802 | 1404 GOLF PARK DRIVE PO BOX 97<br>LAKE ARIEL, PA 18436 |

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| F 0695<br><br>SS=D | Continued from page 31<br><br>broken, preventing it from being secured to the concentrator. The humidification bottle was not dated.<br><br>An observation on August 13, 2025, at 12:00 PM revealed the oxygen humidification bottle remained on the floor with the attachment straps still broken, preventing it from being secured to the concentrator. The humidification bottle was not dated. During an interview at 12:07 PM, Employee 11 confirmed the humidification bottle was on the floor, the straps were broken, and the bottle was not dated.<br><br>During an interview with the Nursing Home Administrator (NHA) on August 14, 2025, at 1:30 PM, the above observations and findings were reviewed with the NHA and confirmed the humidification bottles should not be stored directly on the ground. The NHA indicated that bags should be placed around the bottles and dated when the bottles were last changed.<br><br>28 Pa. Code 211.10 (c) Resident care policies.<br><br>28 Pa. Code 211.12 (c)(d)(1)(3)(5) Nursing services. | F 0695 | | |
| F 0697<br><br>SS=D | | F 0697 | | |

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| F 0697<br><br>SS=D | Continued from page 32<br><br>483.25(k) Pain Management<br><br>§483.25(k) Pain Management.<br>The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.<br><br>This REQUIREMENT is not met as evidenced by: | F 0697 | Resident #19 Morphine order clarified to indicate levels of pain. Cannot go back and retro-correct non-pharmacology interventions for resident #19.<br><br>To identify like residents that have the potential to be affected DON/designee audited all residents with PRN pain medication to ensure that residents pain levels are clarified in the physician order and non-pharmacological interventions being offered prior to administration of the medication.<br><br>To prevent this from recurring licensed staff will be educated on pain management by the DON/designee.<br><br>To monitor and maintain ongoing compliance DON/designee to audit 5 residents x4 weeks then monthly x 2 months to ensure that pain levels are completed and non-pharmacological interventions offered prior to administration of the medication. Results to QAPI for | Completion Date: **09/12/2025** Status: **APPROVED** Date: **09/03/2025** |

| 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 0697<br><br>SS=D | Continued from page 33 | F 0697 | recommendations and follow-up. | |

| 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 0697<br><br>SS=D | Continued from page 34<br><br>Based on clinical record review and select facility policy review and staff interview, it was determined the facility failed to attempt non-pharmacological interventions to alleviate pain prior to the administration of a narcotic pain medication prescribed on an as needed basis for one resident out of 25 sampled residents (Resident 19).<br><br>Findings include:<br><br>A review of the facility's policy entitled "Pain Management" with a policy review date of February 1, 2025, indicated that non- pharmalogical interventions will be attempted prior to the admission of a PRN (as needed) medication, If the nonpharmacological interventions fail then with corresponding intensity ratings, the resident will be administered the medication ordered for the corresponding pain rating within the PRN order.<br><br>A clinical record review revealed that Resident 19 was admitted to the facility on December 8, 2022, with diagnoses that included major depressive | F 0697 | | |

| 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 0697<br><br>SS=D | Continued from page 35<br><br>disorder (a mood disorder that causes a 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) and unspecified dementia with unspecified severity with agitation (a condition in which a person has memory loss and thinking problems due to brain changes, with the exact type and stage not yet identified. The person also shows signs of restlessness or irritability, such as pacing or difficulty sitting still.).<br><br>A review of Resident 19's admission Minimum Data Set assessment (MDS-a federally mandated standardized assessment process conducted periodically to plan resident care) dated May 19, 2025, revealed that Resident 19 was severely cognitively impaired with no BIMS score (Brief 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 99 or no BIMS score indicates the resident was unable to complete the interview). | F 0697 | | |

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| F 0697<br><br>SS=D | Continued from page 36<br><br>A review of Resident 19s clinical record revealed a physicians order dated April 11, 2024, for Acetaminophen 325 mg, chewable tablet, give 2 tablets by mouth every four hours as needed (PRN) for pain scale of 1-3 (pain scale where 1 is the least amount of pain and 10 is the worst amount), not to exceed 3 grams in 24 hours.<br><br>Further review of Resident 19s clinical record revealed a physicians order dated April 25, 2025, for Acetaminophen 650 mg tablet, extended release, administer twice daily at 9:00 AM and 9:00 PM for pain management not to exceed 3000 mg in 24 hours. The physicians order did not identify a level of pain (such as mild, moderate or severe or a pain scale of 0-10 (a scale to evaluate pain where 0 is no pain and 10 is severe pain)<br><br>Continued review of Resident 19s clinical record revealed a physicians order dated July 26, 2025, for Morphine Sulfate oral solution (opioid pain medication) 100 mg/5 ml, (20 mg/ml), amount to | F 0697 | | |

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| F 0697<br><br>SS=D | Continued from page 37<br><br>administer 0.25 ml. PRN for pain/SOB (shortness of breath).The physicians order did not indicate a level of pain (such as mild, moderate or severe or a pain scale of 0-10.) making it difficult for staff to determine which medication to administer as both medications are used for different pain level intensity as stated in the facility policy.<br><br>A review the resident's electronic Medication Administration Record (eMAR is used to document medications taken by each resident) dated August, 2025, revealed that the PRN Morphine Sulphate solution (opioid pain medication) was administered without any documented attempts of nonpharmacological interventions and without assessing Resident 19 for a pain level to determine if a non-opioid medication would be appropriate on the following dates as follows:<br><br>August 12, 2025, at 7:43 PM, administered PRN opioid pain medication without assessing Resident 19 for a pain level to determine if a non-opioid medication would be appropriate and without | F 0697 | | |

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| F 0697<br><br>SS=D | Continued from page 38<br><br>attempted nonpharmacological interventions.<br><br>August 14, 2025, at 4:10 AM, administered PRN opioid pain medication without assessing Resident 19 for a pain level to determine if a non-opioid medication would be appropriate and without attempted nonpharmacological interventions.<br><br>An interview was conducted with the NHA (Nursing Home Administrator) on August 15, 2025, at 9:30 AM, to review the above findings related to the facility failure to assure that licensed nursing staff attempted non-pharmacological interventions prior to administering analgesic pain medication that included opioids.<br><br>28 Pa. Code 211.5(f) Medical records<br><br>28 Pa. Code 211.12 (c)(d)(1)(5) Nursing Services | F 0697 | | |
| F 0809<br><br>SS=E | | F 0809 | | |

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| F 0809<br><br>SS=E | Continued from page 39<br><br>483.60(f)(1)-(3) Frequency of Meals/Snacks at Bedtime<br><br>§483.60(f) Frequency of Meals<br>§483.60(f)(1) Each resident must receive and the facility must provide at least three meals daily, at regular times comparable to normal mealtimes in the community or in accordance with resident needs, preferences, requests, and plan of care.<br><br>§483.60(f)(2)There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except when a nourishing snack is served at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span.<br><br>§483.60(f)(3) Suitable, nourishing alternative meals and snacks must be provided to residents who want to eat at non-traditional times or outside of scheduled meal service times, consistent with the resident plan of care.<br><br>This REQUIREMENT is not met as evidenced by: | F 0809 | Resident#28, #32, #69 and 90 currently being offered HS snacks.<br><br>To identify like residents that have the potential to be affected an audit was completed of current residents to ensure that snacks being offered.<br><br>To prevent this from recurring. DON/designee will educate the nursing staff on offering HS snacks to the residents.<br><br>To monitor and maintain ongoing compliance. DON/designee will audit 5 residents weekly x 4 then monthly x 2 to ensure that snacks are being offered by the nursing staff. Results to QAPI for recommendations and follow-up. | Completion Date: **09/12/2025**<br>Status: **APPROVED**<br>Date: **09/02/2025** |

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| F 0809<br><br>SS=E | Continued from page 40<br><br>Based on a review of scheduled facility mealtimes, select facility policy, and resident and staff interviews, it was determined that the facility failed to consistently provide snacks as desired by residents, including experiences reported by four out of eight residents during a group interview (Residents 28, 32, 69, and 90).<br><br>Findings include:<br><br>A review of the facility policy titled Meal Times and Frequency Policy, last reviewed by the facility on February 1, 2025, revealed that it is the facility policy that there will be no more than 14 hours between a substantial evening meal (dinner) and breakfast the following day; except when a nourishing snack is served at bedtime, up to 16 hours may elapse between a substantial evening meal (dinner) and breakfast the following day if a resident group agrees to this meal span.<br><br>A review of the facility's scheduled mealtimes revealed that the time between dinner and breakfast the next day exceeds 14 hours.<br><br>Specifically, residents residing in the North Nursing Unit Area 1 are scheduled to receive dinner at 4:40 PM and receive breakfast at 7:10 AM. The scheduled time between dinner and breakfast the next day is 14 hours and 30 | F 0809 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC) | (XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION: | (X3) DATE SURVEY COMPLETED: |
|---|---|---|---|
| | 395493 | A. BLDG: __00_____ B. WING: _____ | 08/15/2025 |

| NAME OF PROVIDER OR SUPPLIER: | STREET ADDRESS, CITY, STATE, ZIP CODE: |
|---|---|
| JULIA RIBAUDO EXTENDED CARE CENTER<br>STATE LICENSE NUMBER: 101802 | 1404 GOLF PARK DRIVE PO BOX 97<br>LAKE ARIEL, PA 18436 |

| (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 0809<br><br>SS=E | Continued from page 41<br><br>minutes.<br>Residents residing in the North Nursing Unit Area 2 are scheduled to receive dinner at 5:00 PM and receive breakfast at 7:20 AM. The scheduled time between dinner and breakfast the next day is 14 hours and 20 minutes. Residents residing in the South Nursing Unit Area 1 are scheduled to receive dinner at 4:50 PM and receive breakfast at 7:15 AM. The scheduled time between dinner and breakfast the next day is 14 hours and 25 minutes.<br><br>Residents residing in the South Nursing Unit Area 2 are scheduled to receive dinner at 5:15 PM and receive breakfast at 7:30 AM. The scheduled time between dinner and breakfast the next day is 14 hours and 15 minutes.<br><br>During a resident council interview on August 13, 2025, at 10:00 AM, four out of eight residents (Residents 28, 32, 69, and 90) indicated that a snack is not consistently offered in the evenings. Resident 69 explained that on occasion she is offered a snack, but it does not happen often. Residents 28, 32, and 90 reported not being offered an evening snack.<br><br>During an interview on August 14, 2025, at approximately 2:00 PM, the Nursing Home Administrator (NHA) provided a list of the rotating available snacks for residents. The NHA was not able to provide documented evidence that snacks were consistently offered to residents in the evening. The NHA confirmed it is the facilitys policy to offer residents nourishing snacks in the evening. | F 0809 | | |

| 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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| | 395493 | A. BLDG: __00_____ B. WING: _____ | 08/15/2025 |

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| **JULIA RIBAUDO EXTENDED CARE CENTER** STATE LICENSE NUMBER: **101802** | **1404 GOLF PARK DRIVE PO BOX 97 LAKE ARIEL, PA 18436** |

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| F 0809<br><br>SS=E | Continued from page 42<br><br>28 Pa. Code 211.12 (d)(3)(5) Nursing services. | F 0809 | | |
| F 0925<br><br>SS=E | | F 0925 | | |

| 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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| | 395493 | A. BLDG: __00_____ B. WING: _____ | 08/15/2025 |

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| F 0925<br><br>SS=E | Continued from page 43<br><br>483.90(i)(4) Maintains Effective Pest Control Program<br><br>§483.90(i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents.<br><br>This REQUIREMENT is not met as evidenced by: | F 0925 | The facility cannot go back and retro-correct the pest control concern. Pest control strips were added to the community to decrease pest concerns. NHA has pest control services on weekly/as needed schedule to tour facility to ensure that pest control techniques are effective.<br><br>This has the ability to affect all residents.<br><br>To prevent this from recurring. NHA/designee will educate staff on the Pest Control Policy. NHA has pest control services on weekly/as needed schedule to tour facility to ensure that pest control techniques are effective.<br><br>To monitor and maintain ongoing compliance. NHA/designee will complete weekly rounds with Pest control technician weekly x 4 than monthly x 2 to ensure that pest control techniques are effective. NHA/designee will interview 5 alert and oriented residents to verify that | Completion Date: **09/12/2025** Status: **APPROVED** Date: **09/02/2025** |

| 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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| | 395493 | A. BLDG: __00_____ B. WING: _____ | 08/15/2025 |

| NAME OF PROVIDER OR SUPPLIER: | STREET ADDRESS, CITY, STATE, ZIP CODE: |
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| **JULIA RIBAUDO EXTENDED CARE CENTER** STATE LICENSE NUMBER: **101802** | **1404 GOLF PARK DRIVE PO BOX 97 LAKE ARIEL, PA 18436** |

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| F 0925<br><br>SS=E | Continued from page 44 | F 0925 | the techniques are effective. Results to QAPI for recommendations and follow-up. | |

| 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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| | 395493 | A. BLDG: 00<br>B. WING: | 08/15/2025 |

| NAME OF PROVIDER OR SUPPLIER: | STREET ADDRESS, CITY, STATE, ZIP CODE: |
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| JULIA RIBAUDO EXTENDED CARE CENTER<br>STATE LICENSE NUMBER: 101802 | 1404 GOLF PARK DRIVE PO BOX 97<br>LAKE ARIEL, PA 18436 |

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| F 0925<br><br>SS=E | Continued from page 45<br><br>Based on observations, a review of facility-provided documents, and resident and staff interviews, it was determined the facility failed to maintain an effective pest control program on two of two nursing units (South Nursing B Hall and North Nursing D Hall) and in the North Nursing Resident Dining/Lounge area. In addition, two residents out of twenty-five sampled (Residents 62 and 81) and six residents out of eight during a resident group interview (Residents 26, 28, 32, 49, 69, and 90) reported ongoing problems with small black flies, gnats, or ants in resident rooms and common areas.<br><br>Findings include:<br><br>A review of a facility policy entitled Pest Control Policy that was last reviewed on February 1, 2025, indicated routine pest control procedures will be in place to prevent pest infiltration and contracted pest services will document all visits along with actions taken.<br><br>A review of the facilitys current contract with the | F 0925 | | |

| 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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| | 395493 | A. BLDG: 00<br>B. WING: | 08/15/2025 |

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| F 0925<br><br>SS=E | Continued from page 46<br><br>pest management contractor signed and dated August 12, 2019, revealed year-round protection against pests (except for gnats, outdoor pests and other free flying insects such as mosquitos, lawn insects and pests) and an inspection and report with each visit.<br><br>A review of Resident Council Meeting minutes dated June 26, 2025, and July 29, 2025, indicated that residents reported observations of small black flies/gnats and ants were observed in their rooms and resident common areas.<br><br>During a resident council interview on August 13, 2025, at 10:00 AM, six out of eight residents (Residents 26, 28, 32, 49, 69, and 90) reported ongoing concerns with gnats, flies, or ants in their rooms or resident common areas throughout the facility. The six residents described seeing multiple flying insects or pests throughout the day.<br><br>During an interview with Resident 81 on August 12, | F 0925 | | |

| 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 0925<br><br>SS=E | Continued from page 47<br><br>2025, at 10:25 AM, small black flies were reported and observed during the interview flying in the residents room. Resident 81 reported the facility was made aware and a few weeks ago, the bug guy was here to spray for insects but they were still observed. Additionally, the resident pointed out the bug light that was placed on the dresser and reported family bought it to help get rid of the black flies.<br><br>An observation on August 12, 2025, at 2:15 PM revealed small flying insects in the B nursing hallway.<br><br>An observation on August 12, 2025, at 2:20 PM revealed several small black flying insects on a white shower chair in the B hallway.<br><br>An observation in Resident 62s room on August 13, 2025, at 12:15 PM, revealed several small black flies flying around the room and the resident reported the facility was aware. The resident indicated the flies and ants were on-going over the last few months despite the facility being informed. | F 0925 | | |

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| F 0925<br><br>SS=E | Continued from page 48<br><br>Observation of the North Nursing Unit resident pantry area on August 13, 2025, at 12:30 PM, revealed several small black flies/gnats flying around the garbage can and ice machine.<br><br>A review of facility-provided pest control invoices revealed the following:<br><br>Invoice #667 (May 24, 2025): Documented two pesticide treatments but no description of services performed.<br><br>Invoice #680 (June 26, 2025): Noted drain flies in the kitchen and hallways and indicated need to really clean all restroom floors and check on pipe in kitchen and documented two pesticide treatments.<br><br>Invoice #700 (July 31, 2025): Documented service to all rooms, restrooms, dining areas, and the kitchen, including baseboard spraying and bait station checks, with two pesticide treatments applied. | F 0925 | | |

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| F 0925<br><br>SS=E | Continued from page 49<br><br>The facility was unable to provide additional documentation demonstrating consistent pest control follow-up, detailed treatment outcomes, or contractor recommendations for resolving persistent pest issues.<br><br>During an interview with the Nursing Home Administrator on August 15, 2025, at 10:00 AM, the above findings were reviewed. The Administrator acknowledged that the facility continued to experience pest control issues despite treatments and was considering contracting with a different pest control company.<br><br>28 Pa. Code 201.18 (e) (2.1) Management. | F 0925 | | |

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| P 1210 | Management.<br><br>(2) Protection of personal and property rights of the residents, while in the facility, and upon discharge or after death, including the return of any personal property remaining at the facility within 30 days after discharge or death.<br><br>This REGULATION is not met as evidenced by: | P 1210 | Resident #94 received all of his personal belongings upon discharge.<br><br>To identify like residents that have the potential to be affected.<br>DON/designee completed 2-week audit of new admissions to ensure that personal<br>inventory sheets were completed upon admission and discharge of the residents.<br><br>To prevent this from recurring.<br>DON/designee educated the nursing staff on completion of the personal inventory sheet upon admission and discharge of the resident.<br><br>To monitor and maintain ongoing compliance.<br>DON/designee will audit personal inventory sheets of new admission and discharges<br>weekly x 4 then monthly x 2 to ensure being completed and signed per the policy.<br>Results to QAPI for recommendations and follow-up. | Completion Date: **09/12/2025**<br>Status: **APPROVED**<br>Date: **09/02/2025** |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: | (X6) DATE: |
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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC) | (XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION: | (X3) DATE SURVEY COMPLETED: |
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| P 1210 | Continued from page 1<br><br>Based on the review of clinical records and staff interview it was determined that the facility failed to maintain a complete and accurate record of a residents' personal possessions upon admission and discharge for one resident out of three sampled (Resident 94).<br><br>Findings included:<br><br>A review of the clinical record of Resident 94 revealed the resident was admitted to the facility on July 3, 2025, and discharged on July 16, 2025.<br><br>A review of an electronic observation detail report revealed resident 94 arrived to the facility with 4 belongings. Resident 94s inventory list on admission and discharge did not have a resident or responsible party signature present on the electronic record. A review of the residents discharge information revealed no documentation of the residents belongings being released back to the resident upon discharge.<br><br>Interview with the Director of Nursing on August 14, 2025, at approximately 10:30AM revealed the facility was unable to produce any further documentation of the residents belongings being released with the resident on discharge. | P 1210 | | |

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| P 1440 | Personnel policies and procedures.<br><br>(1) The employee's job description, educational background and employment history.<br><br>This REGULATION is not met as evidenced by: | P 1440 | Employee #5, #7 and #8 have signed job descriptions.<br><br>To identify like individuals that have the potential to be affected.<br>NHA/designee audit of new hires in the last 14 days to ensure job description signed by the employee.<br><br>To prevent this from recurring.<br>Human Resources will be educated by NHA/designee on Personnel policies and procedures.<br><br>To monitor and maintain ongoing compliance.<br>NHA/designee to audit new personnel files weekly x4 then monthly x 2 to ensure personnel files contain job description. Results to QAPI for recommendations and follow-up. | Completion Date: **09/12/2025**<br>Status: **APPROVED**<br>Date: **09/02/2025** |
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| P 1440 | Continued from page 3<br><br>Based on staff interviews and a review of employee personnel records, it was determined that the facility failed to ensure employees' personnel records contained the employees job description for three employees out of five reviewed (Employees 5, 7, and 8).<br><br>Findings include:<br><br>A review of the personnel file for Employee 7, Nurse Aide, revealed a hire date of May 14, 2025. A review of the personnel record revealed no documented evidence of Employee 7s job description (a written document that outlines the duties, responsibilities, and qualifications for a specific role within a facility).<br><br>A review of the personnel file for Employee 5, Activities Aide, revealed a hire date of May 15, 2025. A review of the personnel record revealed no documented evidence of Employee 5s job description.<br><br>A review of the personnel file for Employee 8, Dietary Aide, revealed a hire date of August 7, 2025. A review of the personnel record revealed no documented evidence of Employee 7s job description.<br><br>During an interview on August 15, 2025, at approximately 10:30 AM, the Nursing Home Administrator confirmed the | P 1440 | | |

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| | 395493 | A. BLDG: 00<br>B. WING: | 08/15/2025 |

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| P 1440 | Continued from page 4<br><br>facility could not produce documented evidence that the personnel files contained a job description for each of the three employees job description for three of five personnel files reviewed. | P 1440 | | |
| P 1470 | Personnel policies and procedures.<br><br>(4) A determination by a health care practitioner that the employee, as of the employee's start date, is free from the communicable diseases or conditions listed in § 27.155 (relating to restrictions on health care practitioners).<br><br>This REGULATION is not met as evidenced by: | P 1470 | Employee #6 received her physical.<br><br>To identify like residents that have the potential to be affected. NHA/designee to audit new hire files for the last 14 days to ensure personnel files contain employee physical.<br><br>To prevent this from recurring. Human Resources educated by NHA/designee on Personnel policies and procedures.<br><br>To monitor and maintain ongoing compliance. NHA/designee to audit new personnel files weekly x4 then monthly x 2 to ensure personnel files contain employee physical. Results to QAPI for recommendations and follow-up. | Completion Date: **09/12/2025** Status: **APPROVED** Date: **09/02/2025** |

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| JULIA RIBAUDO EXTENDED CARE CENTER<br>STATE LICENSE NUMBER: 101802 | 1404 GOLF PARK DRIVE PO BOX 97<br>LAKE ARIEL, PA 18436 |

| (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 |
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| P 1470 | Continued from page 5<br><br>Based on staff interviews and a review of employee personnel records, it was determined that the facility failed to ensure employees were assessed by a healthcare practitioner and determined to be free from communicable diseases or conditions prior to providing resident care for for one employee out of five reviewed (Employee 6).<br><br>Findings include:<br><br>A review of the personnel file for Employee 6, Licensed Practical Nurse, revealed a hire date of July 21, 2025. The facility could not provide documentation showing that a healthcare practitioner had determined the employee was free from communicable disease prior to or at the time of hire.<br><br>During an interview on August 15, 2025, at 10:30 AM, the Nursing Home Administrator confirmed that the facility did not have a written determination by a healthcare practitioner indicating that Employee 6, LPN, was deemed free from communicable disease as required. | P 1470 | | |
| P 5520 | | P 5520 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC) | (XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION: | (X3) DATE SURVEY COMPLETED: |
|---|---|---|---|
| | 395493 | A. BLDG: 00<br>B. WING: | 08/15/2025 |

| NAME OF PROVIDER OR SUPPLIER: | STREET ADDRESS, CITY, STATE, ZIP CODE: |
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| **JULIA RIBAUDO EXTENDED CARE CENTER**<br>STATE LICENSE NUMBER: **101802** | **1404 GOLF PARK DRIVE PO BOX 97 LAKE ARIEL, PA 18436** |

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|---|---|---|---|---|
| P 5520 | Continued from page 6<br><br>Nursing services.<br><br>(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.<br><br>This REGULATION is not met as evidenced by: | P 5520 | The facility cannot correct the CNA staffing hours on the cited dates; however, efforts are continuously being made to maintain the staffing hours within regulatory guidelines. Moving forward the facility will make good faith efforts by continuing to recruit staff by participating in job fairs, offering sign on and referral bonuses and utilizing internal/external resources in the event of staffing requirement deficits<br><br>RDCS will re-educate the NHA, Nursing Administration, RN Supervisors, and Scheduler and HR/Payroll staff on PA staffing ratio requirements.<br><br>To monitor and maintain ongoing compliance, the NHA/designee will audit the CNA staffing ratios weekly times 4 weeks, and then monthly x 2 The Audit outcomes will be presented to the QAPI Committee for further review and recommendations. | Completion Date: **09/12/2025** Status: **APPROVED** Date: **09/02/2025** |

| 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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| | 395493 | A. BLDG: 00<br>B. WING: | 08/15/2025 |

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| P 5520 | Continued from page 7<br><br>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 for 45 shifts out of 63 reviewed.<br><br>Findings include:<br><br>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, based on the facility's census:<br><br>May 21, 2025, 8.59 nurse aides on the day shift, versus the required 9.1, for a census of 91<br>May 23, 2025, 8.25 nurse aides on the day shift, versus the required 9.1, for a census of 91<br>May 24, 2025, 6.88 nurse aides on the day shift, versus the required 8.9, for a census of 89<br>May 25, 2025, 8.06 nurse aides on the day shift, versus the required 9, for a census of 90<br>May 26, 2025, 9.19 nurse aides on the day shift, versus the required 9.2, for a census of 92<br>July 3, 2025, 8.97 nurse aides on the day shift, versus the required 9.4, for a census of 94<br>July 5, 2025, 7.16 nurse aides on the day shift, versus the required 9.3, for a census of 93<br>July 6, 2025, 6.72 nurse aides on the day shift, versus the | P 5520 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC) | (XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION: | (X3) DATE SURVEY COMPLETED: |
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|---|---|---|---|---|
| P 5520 | Continued from page 8<br><br>required 9.2, for a census of 92<br>July 7, 2025, 8.22 nurse aides on the day shift, versus the required 9.2, for a census of 92<br>August 8, 2025, 8.09 nurse aides on the day shift, versus the required 9, for a census of 90<br>August 9, 2025, 8.06 nurse aides on the day shift, versus the required 9.1, for a census of 91<br>August 10, 2025, 9.19 nurse aides on the day shift, versus the required 9.2, for a census of 92<br>August 11, 2025, 7.91 nurse aides on the day shift, versus the required 9.2, for a census of 92<br>August 14, 2025, 8 nurse aides on the day shift, versus the required 9, for a census of 90<br><br>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 1:11 on the evening shift, based on the facility's census:<br>May 20, 2025, 7.25 nurse aides on the evening shift, versus the required 8.27, for a census of 91<br>May 23, 2025, 7.41 nurse aides on the evening shift, versus the required 8.27, for a census of 91<br>May 24, 2025, 7.56 nurse aides on the evening shift, versus the required 8.09, for a census of 89<br>May 25, 2025, 7.56 nurse aides on the evening shift, versus the required 8.18, for a census of 90<br>May 26, 2025, 6.31 nurse aides on the evening shift, versus the required 8.36, for a census of 92<br>July 1, 2025, 6.03 nurse aides on the evening shift, versus | P 5520 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC) | (XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION: | (X3) DATE SURVEY COMPLETED: |
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|---|---|---|---|---|
| P 5520 | Continued from page 9<br><br>the required 8.27, for a census of 91<br>July 3, 2025, 6.84 nurse aides on the evening shift, versus the required 8.55, for a census of 94<br>July 4, 2025, 6.09 nurse aides on the evening shift, versus the required 8.45, for a census of 93<br>July 5, 2025, 6 nurse aides on the evening shift, versus the required 8.45, for a census of 93<br>July 6, 2025, 6.59 nurse aides on the evening shift, versus the required 8.36, for a census of 92<br>July 7, 2025, 6.56 nurse aides on the evening shift, versus the required 8.36, for a census of 92<br>August 8, 2025, 8 nurse aides on the evening shift, versus the required 8.18, for a census of 90<br>August 9, 2025, 8.19 nurse aides on the evening shift, versus the required 8.27, for a census of 91<br>August 10, 2025, 8.12 nurse aides on the evening shift, versus the required 8.36, for a census of 92<br>August 12, 2025, 7.66 nurse aides on the evening shift, versus the required 8.27, for a census of 91<br>August 14, 2025, 7.5 nurse aides on the evening shift, versus the required 8.18, for a census of 90<br><br>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 1:15 on the night shift, based on the facility's census:<br>May 20, 2025, 4.56 nurse aides on the night shift, versus the required 6.07, for a census of 91<br>May 22, 2025, 5.62 nurse aides on the night shift, versus | P 5520 | | |

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|---|---|---|---|---|
| P 5520 | Continued from page 10<br><br>the required 6.07, for a census of 91<br>May 23, 2025, 5.62 nurse aides on the night shift, versus the required 6.07, for a census of 91<br>May 26, 2025, 6.12 nurse aides on the night shift, versus the required 6.13, for a census of 92<br>July 1, 2025, 5.09 nurse aides on the night shift, versus the required 6.07, for a census of 91<br>July 3, 2025, 5.06 nurses on the night shift, versus the required 6.27, for a census of 94<br>July 4, 2025, 4.62 nurse aides on the night shift, versus the required 6.2, for a census of 93<br>July 6, 2025, 6.06 nurse aides on the night shift, versus the required 6.13, for a census of 92<br>July 7, 2025, 5.03 nurse aides on the night shift, versus the required 6.13, for a census of 92<br>August 8, 2025, 5.59 nurse aides on the night shift, versus the required 6, for a census of 90<br>August 9, 2025, 5.62 nurse aides on the night shift, versus the required 6.07, for a census of 91<br>August 10, 2025, 5.09 nurse aides on the night shift, versus the required 6.13, for a census of 92<br>August 11, 2025, 5.69 nurse aides on the night shift, versus the required 6.13, for a census of 92<br>August 12, 2025, 5.12 nurse aides on the night shift, versus the required 6.07, for a census of 91<br><br>On the above dates mentioned no additional excess higher-level staff were available to compensate this deficiency. | P 5520 | | |

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|---|---|---|---|---|
| P 5520 | Continued from page 11<br><br>An interview with the Director of Nursing, on August 15, 2025, at approximately 12:00PM, confirmed the facility had not met the required nurse aide to resident ratios on the above dates. | P 5520 | | |
| P 5530 | | P 5530 | | |

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| P 5530 | Continued from page 12<br><br>Nursing services.<br><br>(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.<br><br>This REGULATION is not met as evidenced by: | P 5530 | The facility cannot correct the LPN staffing hours on the cited dates; however efforts are continuously being made to maintain the staffing hours within regulatory guidelines. Moving forward the facility will make good faith efforts by continuing to recruit staff by participating in job fairs, offering sign on and referral bonuses and utilizing internal/external resources in the event of staffing requirement deficits<br><br>RDCS will re-educate the NHA, Nursing Administration, RN Supervisors, and Scheduler and HR/Payroll staff on PA staffing ratio requirements<br><br>To monitor and maintain ongoing compliance, the NHA/designee will audit the LPN staffing ratios weekly times 4 weeks, and then monthly x 2 The Audit outcomes will be presented to the QAPI Committee for further review and recommendations. | Completion Date: **09/12/2025**<br>Status: **APPROVED**<br>Date: **09/02/2025** |
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| P 5530 | Continued from page 13<br><br>Based on a review of nurse staffing and staff interview, it was determined the facility failed to ensure the minimum licensed practical nurse ratio to resident ratio was provided on each shift for 15 shifts out of 63 reviewed.<br><br>Findings include:<br>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 based on the facility's census.<br><br>May 24, 2025, 3.00 LPNs on the day shift, versus the required 3.56, for a census of 89<br>May 26, 2025, 3.41 LPNs on the day shift, versus the required 3.68, for a census of 92<br>July 4, 2025, 3.00 LPNs on the day shift, versus the required 3.72, for a census of 93<br>July 5, 2025, 3.06 LPNs on the day shift, versus the required 3.72, for a census of 93<br>July 6, 2025, 3.12 LPNs on the day shift, versus the required 3.68, for a census of 92<br>July 7, 2025, 3.22 LPNs on the day shift, versus the required 3.68, for a census of 92<br>August 9, 2025, 3.06 LPNs on the day shift, versus the required 3.64, for a census of 91<br>August 10, 2025, 3.06 LPNs on the day shift, versus the required 3.68, for a census of 92<br><br>A review of the facility's weekly staffing records revealed | P 5530 | | |

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| P 5530 | Continued from page 14<br><br>that on the following dates the facility failed to provide minimum licensed practical nurse (LPN) staff of 1:40 on the night shift based on the facility's census.<br>May 23, 2025, 1.06 LPNs on the night shift, versus the required 2.28, for a census of 91<br>May 26, 2025, 1.00 LPNs on the night shift, versus the required 2.30, for a census of 92<br>July 7, 2025, 2.06 LPNs on the night shift, versus the required 2.30, for a census of 92<br>August 8, 2025, 1.22 LPNs on the night shift, versus the required 2.25, for a census of 90<br>August 9, 2025, 2.19 LPNs on the night shift, versus the required 2.28, for a census of 91<br>August 10, 2025, 2.25 LPNs on the night shift, versus the required 2.30, for a census of 92<br>August 14, 2025, 1.00 LPNs on the night shift, versus the required 2.25, for a census of 90<br><br>On the above dates mentioned no additional excess higher-level staff were available to compensate this deficiency.<br>An interview with the Director of Nursing, on August 15, 2025, at approximately 12:00PM, revealed the facility had not met the required LPN to resident ratios on the above dates. | P 5530 | | |

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| P 5640 | Nursing services.<br><br>(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.<br><br>This REGULATION is not met as evidenced by: | P 5640 | The facility cannot correct the inability to meet the minimum nurse staffing of 3.2 hours of general nursing care to each resident on the cited dates; however, efforts are continuously being made to maintain staffing hours within regulatory guidelines. Moving forward the facility will make good faith efforts by continuing to recruit staff by participating in job fairs, offering sign on and referral bonuses and utilizing internal/external resources in the event of staffing requirement deficits<br><br>RDCS will re-educate the NHA, Nursing Administration, RN Supervisors, and Scheduler and HR/Payroll staff on PA staffing PPD requirements.<br><br>To monitor and maintain ongoing compliance, the NHA/designee will audit daily nursing hours weekly times 4 weeks, and then monthly x 2<br><br>The Audit outcomes will be presented to the QAPI Committee for further review and recommendations. | Completion Date: **09/12/2025** Status: **APPROVED** Date: **09/02/2025** |
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| P 5640 | Continued from page 16<br><br>Based on a review of nurse staffing and resident census and staff interview, it was determined the facility failed to consistently provide minimum general nursing care hours to each resident daily on 17 out of the 21 days reviewed.<br><br>Findings include:<br><br>A review of the facility's staffing levels revealed that on the following dates the facility failed to provide minimum nurse staffing of 3.2 hours of general nursing care to each resident:<br>May 20, 2025 - 3.08 direct care nursing hours per resident.<br>May 23, 2025 - 2.87 direct care nursing hours per resident.<br>May 24, 2025 - 2.98 direct care nursing hours per resident.<br>May 25, 2025 - 3.16 direct care nursing hours per resident.<br>May 26, 2025 - 2.83 direct care nursing hours per resident.<br>July 1, 2025 - 2.98 direct care nursing hours per resident.<br>July 3, 2025 - 2.90 direct care nursing hours per resident.<br>July 4, 2025 - 2.72 direct care nursing hours per resident.<br>July 5, 2025 - 2.74 direct care nursing hours per resident.<br>July 6, 2025 - 2.71 direct care nursing hours per resident.<br>July 7, 2025 - 2.73 direct care nursing hours per resident.<br>August 8, 2025 - 2.94 direct care nursing hours per resident.<br>August 9, 2025 - 2.97 direct care nursing hours per resident.<br>August 10, 2025 - 2.98 direct care nursing hours per resident.<br>August 11, 2025 - 3.07 direct care nursing hours per | P 5640 | | |

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|---|---|---|---|---|
| P 5640 | Continued from page 17<br><br>resident.<br>August 12, 2025 - 3.12 direct care nursing hours per resident.<br>August 14, 2025 - 2.94 direct care nursing hours per resident.<br><br>The facility's general nursing hours were below minimum required levels on the dates noted above.<br><br>An interview with the Director of Nursing on August 15, 2025, at approximately 12:00PM revealed that the facility failed to consistently provide minimum general nursing care hours to each resident daily. | P 5640 | | |

# Certified End Page

**JULIA RIBAUDO EXTENDED CARE CENTER**

**STATE LICENSE NUMBER: 101802**

**SURVEY EXIT DATE: 08/15/2025**

**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