STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395567	A. BLDG: 00 B. WING:	12/12/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
DUNMORE HEALTH CARE CENTER STATE LICENSE NUMBER: **120902**	**1000 MILL STREET** **DUNMORE, PA 18512**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0000	INITIAL COMMENT Based on a Medicare/Medicaid Recertification, and State Licensure survey completed on December 12, 2024, it was determined that Dunmore Health Care Center was not in compliance with the following requirements of 42 CFR Part 483 Subpart B Requirements for Long Term Care Facilities and the 28 PA Code Commonwealth of Pennsylvania Long Term Care Licensure Regulations.	F 0000		
F 0578 SS=D		F 0578		

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 0578 SS=D	Continued from page 1 483.10(c)(6)(8)(g)(12)(i)-(v) Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance	F 0578	Correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. The plan of correction is prepared and executed as a means to continually improve the quality of care and to comply with all applicable state and federal regulatory requirements. Resident 18 is deceased. Advanced directives have been offered to resident 74 and documented in clinical chart. To identify residents with the potential to be affected SS/designee will audit current residents to determine if advanced directives have been offered, any resident not offered, will be offered and documented in clinical record. To prevent from re-occurring Social	Completion Date: **01/09/2025** Status: **APPROVED** Date: **12/23/2024**

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F 0578 SS=D	Continued from page 2 directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by:	F 0578	Service Director will be educated by NHA/designee on the proper process for advanced directives. 4.To monitor and maintain compliance Social Service Director/designee will audit new admissions for advanced directives weekly x 4 then monthly x 2. All findings will be brought to QAPI committee.	

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F 0578 SS=D	Continued from page 3 Based on a review of clinical records and select facility policy and staff interview, it was determined the facility failed to demonstrate it had ascertained if a resident had an advance directive upon admission and whether the resident would like information to formulate an advance directive for two out of 18 sampled residents (Residents 74 and 18). Findings included: A review of a facility entitled "Advance Care Planning meeting Protocol" last reviewed by the facility on December 2, 2024, indicated that it was the policy of the facility that upon admission to the facility, the appropriate team member would meet with the resident and offer to formulate an advance directive to ensure their preferences (Living Wills, Medical Powers of Attorney, etc.) are recorded in their medical record and further used to develop their plan of care. Social Services, along with other team members as needed, will meet with the resident and family members within a reasonable timeframe (3-5 days from admission) to discuss	F 0578		

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F 0578 SS=D	Continued from page 4 pertinent information regarding the resident's wishes. A review of Pennsylvania Statute Title 20: Chapter 54: Healthcare revealed that an advance health care directive is a health care power of attorney, a living will, or a written combination of a health care power of attorney and a living will. A review of the clinical record revealed that Resident 74 was admitted to the facility on October 31, 2024, with diagnoses that included esophageal cancer (a tumor that occurs in esophagus - tube which connects from throat to the stomach, resulting in difficulty in swallowing, chest pain, cough, sudden weight loss and heartburn), metabolic encephalopathy (a condition in which brain function is disturbed either temporarily or permanently due to different diseases or toxins in the body and may be reversible if the preexisting disorders are treated), and protein calorie malnutrition (the state of inadequate intake of food as a source of protein, calories, and other essential nutrients occurring in the absence of significant inflammation, injury, or	F 0578		

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F 0578 SS=D	Continued from page 5 another condition that elicits a systemic inflammatory response). Review of Resident 74's admission Minimum Data Set (MDS- a federally mandated standardized assessment process completed periodically to plan resident care) dated November 5, 2024, revealed the resident was cognitively intact with a BIMS (brief interview mental screening tool used to screen and identify cognitive impairment) score of 15 (12 to 15 indicates intact cognition). Resident 74's clinical record revealed a "Pennsylvania Physician Orders for Life-Sustaining Treatment" (POLST- The POLST is not intended to replace an advance health care directive document or other medical orders. The POLST process and health care decision-making works best when the person has appointed a health care agent to speak for them when they become unable to speak for themselves. A health care agent can only be appointed through an advance health care directive or a health care power of attorney), but no	F 0578		

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F 0578 SS=D	Continued from page 6 documented evidence of an Advance Directive or if the facility asked the resident if he would like information to formulate an advance directive. Further review of Resident 74's clinical record failed to reveal documented evidence that facility staff offered the resident the opportunity to formulate an Advanced Directive. Additionally, there was no documented evidence that the facility determined if the resident had or did not have an Advance Directive or Healthcare Power of Attorney. A review of the clinical record revealed Resident 18 was admitted to the facility on November 21, 2024, with diagnoses that included unspecified 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). Review of Resident 18's admission Minimum Data Set (MDS- a federally mandated standardized assessment process completed periodically to plan	F 0578		

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F 0578 SS=D	Continued from page 7 resident care) dated November 23, 2024, revealed the resident was severely cognitively impaired. Resident 18's clinical record revealed a "Pennsylvania Physician Orders for Life-Sustaining Treatment" (POLST- The POLST is not intended to replace an advance health care directive document or other medical orders, the POLST indicated the resident was a DNR (do not resituate) but there was no documented evidence of an Advance Directive or evidence that the facility discussed advance directives and offered the opportunity to formulate one with the residents representative. Further review of Resident 18's clinical record failed to reveal documented evidence that facility staff offered the resident the opportunity to formulate an Advanced Directive. Additionally, there was no documented evidence that the facility determined if the resident had or did not have an Advance Directive or Healthcare Power of Attorney. An interview with the social services director (SSD)	F 0578		

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F 0578 SS=D	Continued from page 8 on December 11, 2024, at 10:30 AM, confirmed there was no documented evidence to indicate the facility had determined if Residents 74 and 18 had or did not have an advance directive upon admission to the facility. The SSD confirmed there was no documented evidence that Resident 72 or Resident 18 were made aware of the right to formulate an advance directive and that information to formulate an advance directive could be requested and provided by the facility. 28 Pa. Code 201.29 (a)(b) Resident rights	F 0578		
F 0623 SS=B		F 0623		

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F 0623 SS=B	Continued from page 9 483.15(c)(3)-(6)(8) Notice Requirements Before Transfer/Discharge §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)	F 0623	Community cannot correct past practices. Community cannot correct past practices. 3.To prevent from re-occurring DON/designee will educate licensed staff on transfer/discharge paperwork requirement. DON/designee will educate BOM to ensure paperwork has been received timely. 4.To monitor and maintain compliance DON/designee will audit 3 transfers per week x 4 then monthly x 2 to ensure discharge/transfer paperwork has been received. All findings will be brought to QAPI committee.	Completion Date: **01/09/2025** Status: **APPROVED** Date: **12/23/2024**

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F 0623 SS=B	Continued from page 10 (1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and	F 0623		

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F 0623 SS=B	Continued from page 11 (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(k). This REQUIREMENT is not met as evidenced by:	F 0623		

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F 0623 SS=B	Continued from page 12 Based on a review of clinical records and facility-initiated transfer notices and a staff interview, it was determined the facility failed to provide written notices of facility-initiated hospital transfers to the resident and their representative for one resident out of the 18 sampled (Resident 2). Findings include: A review of Resident 2's clinical record revealed the resident was initially admitted to the facility on July 14, 2016 with diagnoses that included chronic obstructive pulmonary disease. A review of the clinical record revealed that Resident 2 was transferred to the hospital on November 20, 2024, and was readmitted to the facility on November 26, 2024. A review of the clinical record failed to reveal documented evidence the facility provided the resident and the resident's responsible party (RP) with a written notice of the facility-initiated transfer	F 0623		

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F 0623 SS=B	Continued from page 13 and reason for the transfer on November 20, 2024. An interview with the Nursing Home Administrator on December 12, 2024, at 9:10am, confirmed the facility had no documented evidence Resident 2's responsible parties were provided with a written notice of the facility initiated transfer that was initiated on November 20, 2024. 28 Pa. Code 201.14(a) Responsibility of licensee.	F 0623		
F 0625 SS=B		F 0625		

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F 0625 SS=B	Continued from page 14 483.15(d)(1)(2) Notice of Bed Hold Policy Before/Upon Trnsfr §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by:	F 0625	Community cannot correct past practices. To identify residents with the potential to be affected DON/Designee will audit the last 7 days of discharges to ensure bed hold policy requirement is met. To prevent from re-occurring DON/designee will educate licensed staff on bed hold policy requirement. DON/designee will educate BOM to ensure paperwork has been received timely. To monitor and maintain compliance DON/designee will audit 3 transfers per week x 4 then monthly x 2 to ensure bed hold policy has been received. All findings will be brought to QAPI committee.	Completion Date: **01/09/2025** Status: **APPROVED** Date: **12/24/2024**

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F 0625 SS=B	Continued from page 15	F 0625		

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DUNMORE HEALTH CARE CENTER STATE LICENSE NUMBER: **120902**	**1000 MILL STREET DUNMORE, PA 18512**

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F 0625 SS=B	Continued from page 16 Based on a review of clinical records and a staff interview, it was determined that the facility failed to provide written notice of the facility's bed hold policy to a resident and the resident's representative upon the resident's transfer to the hospital for one resident out of the 18 sampled (Resident 2). Findings include: A review of the clinical record revealed that Resident 2 required transfer to the hospital on November 20, 2024, and was readmitted to the facility on November 26, 2024. There was no documented evidence that the residents and/or their responsible parties or legal representatives were provided written information about the facility's bed-hold policy (an agreement for the facility to hold a bed for an agreed upon rate during a hospitalization) at the time of transfer. During an interview on December 12, 2024, at approximately 9:10 am, the Nursing Home	F 0625		

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F 0625 SS=B	Continued from page 17 Administrator (NHA) was unable to provide evidence that the facility made Resident 2 and their representative, aware of a facility's bed-hold and reserve bed payment policy upon transfer to the hospital. 28 Pa Code 201.18 (e)(1) Management 28 Pa Code 201.29 (a) Resident rights	F 0625		
F 0641 SS=D		F 0641		

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F 0641 SS=D	Continued from page 18 483.20(g) Accuracy of Assessments §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by:	F 0641	Resident MDS was corrected on 12/9/2024. To identify residents with the potential to be affected MDS assessments in the last 14 days will be reviewed for accuracy by MDS coordinator. To prevent this from recurring education will be provided to MDS coordinator by regional MDS coordinator regarding MDS accuracy. To monitor and maintain compliance 5 random charts will be reviewed weekly x 4 and then monthly x 2 for accuracy by MDS coordinator/designee. All results will be brought to QAPI committee.	Completion Date: **01/09/2025** Status: **APPROVED** Date: **12/23/2024**

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F 0641 SS=D	Continued from page 19 Based on a review of clinical records and the Resident Assessment Instrument and staff interviews, it was determined the facility failed to ensure the Minimum Data Set Assessments accurately reflected the status of one resident out of 18 sampled (Resident 49). Findings include: A review of the clinical record revealed that Resident 49 was admitted to the facility on September 28, 2024, with diagnoses to have included cardiovascular disease, depression, and diabetes. A review of Resident 49's quarterly review Minimum Data Assessment (MDS-a federally mandated standardized assessment conducted at specific intervals to plan resident care) dated November 2, 2024, revealed in Section P - P0100 Restraints was coded "D Other" to indicate the resident had a form of restraints in place. A review of Resident 49's clinical record failed to reveal that	F 0641		

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F 0641 SS=D	Continued from page 20 the resident had restraints in place. An interview with the Director of Nursing (DON) on December 12, 2024, at 10:00 AM, revealed that Resident 49 did not have physician's orders for restraints or require restraints and confirmed the quarterly MDS November 2, 2024, Section P0100 Restraints was coded in error to indicate the resident had a restraint in place. 28 Pa. Code 201.18(e)(1) Management 28 Pa. Code 211.12(c)(d)(1)(5) Nursing services	F 0641		
F 0684 SS=D		F 0684		

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F 0684 SS=D	Continued from page 21 483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by:	F 0684	Resident documentation cannot be corrected. To identify residents with the potential to be affected, the DON/designee will complete an audit of bowel records for the previous 14 days to ensure all protocols have been followed. To keep from re-occurring, the DON/designee will educate all licensed staff to follow bowel protocol and notify MD of deviation. To monitor and maintain compliance the DON/designee will audit 5 residents bowel protocol and documentation weekly x 4 then monthly x 2, any negative findings will be corrected immediately. All results will be brought to QAPI committee.	Completion Date: **01/09/2025** Status: **APPROVED** Date: **12/23/2024**

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F 0684 SS=D	Continued from page 22 Based on observation, review of clinical records, and resident and staff interviews it was determined the facility failed to provide services consistent with professional standards of practice by failing to follow physician orders for bowel protocol for one resident (Resident 59) out of 18 residents reviewed to promote normal bowel activity to the extent practicable. Findings include: According to the American Academy of Family Physicians (The American Academy of Family Physicians is one of the largest medical organizations in the US founded to promote the science and art of family medicine) the primary goal of constipation management should be symptom improvement, and the secondary goal should be the passage of soft, formed stool without straining at least three times per week. A review of the clinical record revealed that Resident 59 had physician orders dated May 1,	F 0684		

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F 0684 SS=D	Continued from page 23 2024, for the following bowel regimen: - Milk of Magnesia (MOM) Suspension 400 mg/5ML (Magnesium Hydroxide), Give 30 ml by mouth as needed for constipation if no BM (bowel movement) after the third day. -Bisacodyl suppository; 10 mg; insert 1 suppository rectally as needed for constipation if no BM on the fourth day and no result from MOM. -Enema (Mineral Oil), insert 1 application rectally as needed for constipation if no BM on the fifth day and no result from the suppository notify md if no bowel movement. Review of Resident 59's bowel tracking for November 2024, revealed that Resident 59 did not have a bowel movement on November 19, 20, 21, 22, and 23, 2024. Review of Resident's Medication Administration Record (MAR) for November 2024, revealed no	F 0684		

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F 0684 SS=D	Continued from page 24 documented evidence that nursing administered the prescribed bowel protocol during the time period without a bowel movement to promote bowel activity. There was no documented evidence the staff had notified the physician the resident went five consecutive days, November 19, 20, 21, 22, and 23, 2024, without a bowel movement. During an interview with the Director of Nursing (DON) on December 12, 2024, at 9:20 AM, the DON was unable to provide evidence the physician ordered bowel protocol was followed for Resident 59 during the period without bowel activity stated above, nor evidence of timely physician notification. 28 Pa. Code 211.12 (d)(1)(3)(5) Nursing services 28 Pa. Code 211.5(f) Medical records	F 0684		

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F 0688 SS=E	483.25(c)(1)-(3) Increase/Prevent Decrease in ROM/Mobility §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by:	F 0688	Documentation on resident 6 cannot be corrected. Resident 6 will have current restorative program evaluated for effectiveness and appropriateness. To identify residents with the potential to be affected, DON/designee will audit residents currently on restorative nursing to ensure nursing evaluation is present. To prevent from re-occurring DON/designee will educate ADON on process for restorative initiation and regular documentation and evaluation. To monitor and maintain compliance DON/designee will audit 5 resident charts weekly x 4 then monthly x 2 to ensure regular evaluation is completed on RNP. All results will brought to QAPI committee.	Completion Date: **01/09/2025** Status: **APPROVED** Date: **12/24/2024**

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F 0688 SS=E	Continued from page 26 Based on a review of clinical records, select facility policy, and resident and staff interviews, it was determined the facility failed to ensure residents receive appropriate services and assistance to maintain or improve mobility with the maximum practicable independence for one resident out of 18 sampled (Resident 6). Findings include: A review of policy entitled "Restorative Nursing Referral and Process Policy" last reviewed by the facility on December 4, 2024, revealed it is the policy of the facility that Residents who could benefit from the nursing restorative program can be identified at the following times: -on admission -when other assessments are required, such as an MDS assessment -from the 24 hour report and the change of shift report -at morning stand up meeting -at care plan meeting and other resident-focused	F 0688		

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F 0688 SS=E	Continued from page 27 meetings -at risk management meetings such as behavior management, nutrition at risk -during restorative weekly meetings. The procedure to include, a referral from the therapy department, goals can be written in the initial evaluation for resident participation in the restorative program. It was indicated the restorative program is a nursing program and is at the discretion of the nursing restorative coordinator. Further a care plan will be developed for a restorative program. Clinical record review revealed that Resident 6 was admitted to the facility on July 12, 2022, with diagnoses which included diabetes and muscle weakness. A quarterly MDS (Minimum Data Set - a federally mandated standardized assessment conducted at specific intervals to plan resident care) dated November 20, 2024, revealed the resident to be cognitively intact with a BIMS score of 15 (BIMS	F 0688		

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F 0688 SS=E	Continued from page 28 (Brief Interview for Mental Status) is a mandatory tool used to screen and identify the cognitive condition of residents upon admission into a long-term care facility. A score of 13-15 indicates cognitively intact) and required staff assistance for activities of daily living. A review of a physical therapy discharge summary dated May 23, 2024, revealed a recommendation of discharged from therapy services and start restorative nursing program (RNP) for range of motion of bilateral lower extremities. A review a care plan for ADL functional status/rehabilitation dated May 22, 2024, restorative nursing interventions to include active range of motion to left lower extremities for 30 repetitions and passive range of motion to right lower extremity for 30 repetitions. A review of nursing staff documentation dated November 1, 2024, through November 30, 2024, revealed that staff completed RNP exercises for	F 0688		

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F 0688 SS=E	Continued from page 29 Resident 6 daily for between 2 minutes and 30 minutes daily. There were no nursing evaluations of the RNP program to include resident progress, the continuation of the services or the need to revise the program from the inception of the program May 22, 2024, through the end of the survey December 12, 2024. During an interview on December 11, 2024, at approximately 11:00 AM, the Assistant Director of Nursing confirmed residents RNP programs should be evaluated monthly and documented in the medical record. She stated that she had not reviewed any of the programs since taking over the program in May 2024. During an interview December 12, 2024 at 10:00 AM, the Nursing Home Administrator confirmed it is the facility's responsibility and policy to ensure residents receive appropriate services and assistance to maintain or improve mobility with the	F 0688		

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F 0688 SS=E	Continued from page 30 maximum practicable independence. 28 Pa. Code: 211.12(d)(3)(5) Nursing services	F 0688		
F 0690 SS=E	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	F 0690	1. Resident 27 and 74 will have a new 72 hour bowel and bladder diary initiated and based on the results of the assessment an individualized plan will be implemented if indicated. 2. To identify residents with the potential to be affected, DON/designee will audit current residents to ensure a 72 hour bowel and bladder diary was completed as per policy. 3. To prevent from re-occurring DON /designee will educate nursing staff on continence management program. 4. To monitor and maintain DON/Designee will audit new admissions weekly x 4 weeks for evaluation of bladder function and appropriate program, then monthly for 2 months. All findings will be taken to the QAPI committee.	Completion Date: **01/09/2025** Status: **APPROVED** Date: **12/23/2024**

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F 0690 SS=E	Continued from page 31 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. This REQUIREMENT is not met as evidenced by:	F 0690		

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F 0690 SS=E	Continued from page 32 Based on a review of select facility policy, clinical records, and staff interviews it was determined that the facility failed to develop and implement individualized measures for the toileting needs of two residents out of 18 sampled residents for bowel and bladder management (Residents 27 and 74). Findings included: A facility policy entitled "Continence Management Programs" last reviewed by the facility December 2, 2024, indicated that the facility will design a plan to manage incontinence that is developed according to the resident's needs and capabilities. Upon admission, the admitting Nurse will complete a head-to-toe assessment which includes interview of resident and review of underlying conditions such as potential or actual diagnoses that may affect the ability to participate in a continence management program. The nursing staff will identify each resident who is incontinent, assess, and plan appropriate treatment and services to achieve or maintain as much normal urinary and/or bowel function as	F 0690		

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F 0690 SS=E	Continued from page 33 possible. Additionally, the policy indicted that a Continence Evaluation will be conducted to determine if a 72-hour Bowel and Bladder Tracking is indicated. If tracking is indicated, the licensed Nurse will instruct the nursing assistants (NA) to fill out the form. When a new pattern has been identified, a new Continence Evaluation will be completed and the licensed nurse will develop a toileting plan, determining the approaches needed to achieve the goal(s), establish the type of staff intervention needed to meet each resident's goal(s), select equipment and aids needed to be successful and note the interventions, and review the plan as needed to identify any necessary modifications. A review of Resident 27's clinical record revealed that the resident was most recently readmitted to the facility on September 27, 2024, with diagnoses that included sepsis (an infection of the blood stream resulting in a cluster of symptoms such as drop in a blood pressure, increase in heart rate and fever),	F 0690		

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F 0690 SS=E	Continued from page 34 COPD (chronic obstructive pulmonary disease an ongoing lung condition caused by damage to the lungs and the damage results in swelling and irritation), and morbid obesity (is a complex chronic condition that can lead to several serious health issues). A review of the resident's Admission/Readmission Observation completed by Employee 1 RN (registered nurse) dated September 27, 2024, at 4:49 PM, revealed the resident always was incontinent of urine and always incontinent of bowel and required adult incontinence briefs to manage incontinence. Additionally, at the time of the readmission observation assessment, Employee 1 initiated a Continence and Retraining/Scheduled Toileting and Decision/Determination Observation form that indicated bladder and bowel were to be assessed due to readmission. Resident 27's had a history of UTI's (urinary tract infections), functionally was unable to walk to the bathroom which required the	F 0690		

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F 0690 SS=E	Continued from page 35 use of a wheelchair for locomotion, and usually aware of her toileting needs. However, Resident 27's Continence and Retraining/Scheduled Toileting and Decision/Determination Observation form failed to reveal that staff completed a 72-hour bladder and bowel tracking form to assess the resident's continence to potentially implement a scheduled toileting program, as practicable, or develop individualized incontinence management schedule. A review of Resident 27's comprehensive person-centered plan of care revealed the facility failed to indicate the resident's bladder and bowel continence status or her individualized toileting/incontinence management program to ensure the resident's highest practicable level of independence and dignity. During an interview with the Assistant Director of Nursing (ADON) on December 12, 2024, at 9:17 AM, revealed that the facility could not provide	F 0690		

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F 0690 SS=E	Continued from page 36 documented evidence that Resident 27's bladder and bowel continence/incontinence was assessed, and that a 72-hour bladder and bowel tracker was completed as per facility policy. A review of the clinical record revealed that Resident 74 was admitted to the facility on October 31, 2024, with diagnoses that included esophageal cancer (a tumor that occurs in the tube which connects from throat to the stomach resulting in difficulty in swallowing, chest pain, cough, sudden weight loss and heartburn), metabolic encephalopathy (is a condition in which brain function is disturbed either temporarily or permanently due to different diseases or toxins in the body), and protein calorie malnutrition (is the state of inadequate intake of food), A review of the resident's Admission/Readmission Observation completed by the ADON dated October 31, 2024, at 5:05 PM, revealed that the resident was able to stand and pivot from wheelchair with assistance, was alert and oriented	F 0690		

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F 0690 SS=E	Continued from page 37 and understands clear-comprehension, and always continent of urine with use of urinal. The resident's bowel continence section was not completed. A review of Resident 74's admission Minimum Data Set assessment (MDS - a federally mandated standardized assessment process conducted periodically to plan resident care) dated November 5, 2024, revealed that the resident was cognitively intact with a BIMS (brief interview mental screening tool used to screen and identify cognitive impairment) score of 15 (12 to 15 indicates cognitive intact), required substantial/extensive assistance from staff for transfers, and toileting, and toileting hygiene. Additionally, the admission MDS was coded to indicate that a trial urinary and trial bowel toileting program was not attempted and was occasionally incontinent of urine, frequently incontinent of bowel, and was not on a bladder or bowel toileting program.	F 0690		

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F 0690 SS=E	Continued from page 38 Resident 74's clinical record failed to reveal any documented evidence that continence/incontinence status was assessed to develop and implement an individualized toileting or incontinence management program to ensure the resident's highest practicable level of independence and dignity. An interview with the Assistant Director of Nursing (ADON), on December 12, 2024, at 9:30 AM, revealed the facility could not provide documented evidence that upon admission Resident 74's bladder and bowel continence/incontinence was assessed, and that a 72-hour bladder and bowel tracker was completed as per facility policy, and plan of care was fully developed to reflect the resident's toileting needs. At the time of the interview with the ADON, it was confirmed that upon admission the facility failed to assess Resident 27 and Resident 74's bladder and bowel continence/incontinence and failed to complete a 72-hour bladder and bowel tracker as per facility policy, and that the facility failed to fully	F 0690		

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F 0690 SS=E	Continued from page 39 develop a plan of care to reflect the resident's toileting needs to ensure the resident's highest practicable level of independence and dignity. 28 Pa. Code 211.12 (d)(1)(3)(5) Nursing services 28 Pa. Code 211.10(a)(d) Resident care policies	F 0690		
F 0699 SS=D		F 0699		

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F 0699 SS=D	Continued from page 40 483.25(m) Trauma Informed Care §483.25(m) Trauma-informed care The facility must ensure that residents who are trauma survivors receive culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident. This REQUIREMENT is not met as evidenced by:	F 0699	PTSD care plan has been added to resident 78 plan of care. To identify residents with the potential to be affected Social Service Director/designee will audit residents with current PTSD diagnosis to ensure care plan is in place. 3.To prevent from re-occurring NHA/designee will educate Social Service Director to ensure plan of care for residents with PTSD have care plan updated with specific needs. 4.To monitor and maintain compliance Social Service Director/designee will audit new admissions with a diagnosis PTSD weekly x 4 then monthly x 2 to ensure care plan is present and specific needs identified. All results will be brought to QAPI committee.	Completion Date: **01/09/2025** Status: **APPROVED** Date: **12/23/2024**

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F 0699 SS=D	Continued from page 41 Based on a review of clinical records and staff interview, it was determined the facility failed to develop and implement an individualized person-centered plan to render trauma informed care to a resident with a diagnosis of Post-Traumatic Stress Disorder for one out of 18 residents reviewed (Resident 78). Findings include: A review of Resident 78's clinical record revealed the resident was admitted to the facility on April 11, 2024, with diagnoses that included Post Traumatic Stress Disorder (PTSD a mental health condition that's caused by an extremely stressful or terrifying event, either being part of it or witnessing it. Symptoms may include flashbacks, nightmares, severe anxiety, and uncontrollable thoughts about the event). The resident's current care plan, in effect at the time of review on December 11, 2024, did not identify the resident's PTSD symptoms or triggers related to	F 0699		

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F 0699 SS=D	Continued from page 42 this diagnosis and resident specific interventions to meet the resident's needs for minimizing triggers and/or re-traumatization. The facility failed to develop and implement an individualized person-centered plan to address, this resident's diagnosis of PTSD according to standards of practice to promote the resident's emotional well-being and safety. Interview with the Director of Social Services on December 11, 2024, at approximately 11:00 a.m., confirmed she was unaware of the resident's PTSD diagnosis and there had not been a care plan in place to address the resident's diagnoses of PTSD. Interview with the Nursing Home Administrator on December 11, 2024, at 1:00 p.m., confirmed the facility was unable to demonstrate the facility provided culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for resident's experiences and preferences to eliminate or mitigate triggers that	F 0699		

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F 0699 SS=D	Continued from page 43 may cause re-traumatization of the resident. 28 Pa Code 211.12 (d)(3)(5) Nursing services.	F 0699		
F 0744 SS=E		F 0744		

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F 0744 SS=E	Continued from page 44 483.40(b)(3) Treatment/Service for Dementia §483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. This REQUIREMENT is not met as evidenced by:	F 0744	Resident 18 is deceased and resident 19 dementia care plan has been added. To identify other residents with the potential to be affected, the DON/designee completed an audit of all residents with dementia diagnosis to ensure care plan was developed and met residents individualized needs and care. To prevent this from re-occurring, the DON/designee educated the licensed nursing staff on dementia, specific individualized needs and plan of care. To monitor and maintain ongoing compliance, the DON/designee will audit new admissions with a diagnosis of dementia to confirm all care plans meet resident's individualized needs and care weekly then monthly x 2. All results will be brought to QAPI committee.	Completion Date: **01/09/2025** Status: **APPROVED** Date: **12/23/2024**

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F 0744 SS=E	Continued from page 45 Based on a review of clinical records and staff interview, it was determined the facility failed to develop and implement an individualized person-centered plan to address a resident's dementia-related behavioral symptoms for two out of 18 residents (Resident 18 and 19). Findings include: A review of Resident 18's clinical record revealed the resident was admitted to the facility on November 21, 2024, with diagnoses which included 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). A review of Resident 18's Admission Minimum Data Set Assessment (MDS - a federally mandated standardized assessment conducted at specific intervals to plan resident care) dated November 23, 2024, revealed the resident was severely cognitively impaired.	F 0744		

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F 0744 SS=E	Continued from page 46 A review of the resident's current care plan, initially dated November 21, 2024, revealed no documented evidence the facility had developed an individualized person-centered plan for the resident's dementia care, while maximizing the resident's dignity, autonomy, privacy, socialization, independence, choice, and safety and using individualized, non-pharmacological approaches to care, including purposeful and meaningful activities that address the resident's customary routines, interests, preferences, and choices to enhance the resident's well-being. The facility failed to develop and implement an individualized person-centered plan to address, modify and manage this resident's dementia-related behaviors. The resident's care plan for dementia failed to include individualized interventions based on an assessment of the resident's preferences, social/past life history, customary routines, and interests in an effort to manage, modify or decrease the resident's dementia-related behavioral	F 0744		

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F 0744 SS=E	Continued from page 47 symptoms. A review of Resident 19's clinical record revealed the resident was admitted to the facility on July 5, 2022, with diagnoses that included acute dementia. A review of Resident 19's Quarterly Minimum Data Set Assessment (MDS - a federally mandated standardized assessment conducted at specific intervals to plan resident care) dated October 21, 2024, revealed the resident was severely cognitively impaired. A review of the resident's care plan initiated July 18, 2022 for cognitive deficit indicated the resident had a diagnosis of Dementia with Lewy Bodies (Lewy body dementia causes a decline in mental abilities that gradually gets worse over time. People with Lewy body dementia might see things that aren't there. This is known as visual hallucinations. They also may have changes in alertness and attention). A review of the resident's current care plan, initially	F 0744		

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F 0744 SS=E	Continued from page 48 dated April 15, 2024, in effect at the time of the survey ending December 12, 2024, revealed no documented evidence the facility had developed an individualized person-centered plan for the resident's dementia care, while maximizing the resident's dignity, autonomy, privacy, socialization, independence, choice, and safety and using individualized, non-pharmacological approaches to care, including purposeful and meaningful activities that address the resident's customary routines, interests, preferences, and choices to enhance the resident's well-being. The facility failed to develop and implement an individualized person-centered plan to address, modify and manage this resident's dementia-related behaviors. The resident's care plan for dementia failed to include individualized interventions based on an assessment of the resident's preferences, social/past life history, customary routines, and interests in an effort to manage, modify or decrease the resident's dementia-related behavioral symptoms.	F 0744		

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F 0744 SS=E	Continued from page 49 Interview with Nursing Home Administrator on December 12, 2024, at approximately 10:00 AM, confirmed the facility was unable to provide evidence of the development and implementation of an individualized person-centered plan to address the resident's dementia care. 28 Pa Code 211.12 (d)(3)(5) Nursing services	F 0744		
F 0758 SS=E		F 0758		

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F 0758 SS=E	Continued from page 50 483.45(c)(3)(e)(1)-(5) Free from Unnec Psychotropic Meds/PRN Use §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and	F 0758	Resident 19 documentation from facility MD for declination of GDR and use of multiple antidepressants has been added to clinical record. To identify other residents that have the potential to be affected, the DON/designee will complete an audit of concurrent antidepressant medications to ensure justification of use. To prevent this from reoccurring, the DON/designee will educate ADON and MD on proper documentation required for continued use of multiple antidepressant medications. MD will be responsible to comply with the regulation. To monitor and maintain ongoing compliance, the DON/designee will audit pharmacy recommendations for residents with concurrent antidepressant medications monthly x 4 to ensure all MD documentation of declination of GDR and justification of continued use. Any	Completion Date: **01/09/2025** Status: **APPROVED** Date: **12/26/2024**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395567	A. BLDG: __00_____ B. WING: _____	12/12/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
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F 0758 SS=E	Continued from page 51 §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by:	F 0758	missing documentation will be brought to the Medical Director for review. All results will be brought to QAPI committee.	

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 0758 SS=E	Continued from page 52 Based on clinical record review and staff interviews, it was determined the facility failed to ensure the presence of physician documentation of the clinical rationale for the continued administration of an antidepressant medication for one resident out of five sampled residents for unnecessary medication use. (Resident 19). Findings included: A review of Resident 19's clinical record revealed the resident was admitted to the facility on July 5, 2022, with diagnoses that included acute dementia (a chronic condition that causes a decline in mental abilities, such as thinking, remembering, and reasoning, that interferes with daily life). A review of Resident 19's Quarterly Minimum Data Set Assessment (MDS - a federally mandated standardized assessment conducted at specific intervals to plan resident care) dated October 21, 2024, revealed the resident was severely cognitively impaired.	F 0758		

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F 0758 SS=E	Continued from page 53 A review of current Physicians orders dated April 4, 2024, revealed orders for Mirtazapine 15 mg (an antidepressant medication) by mouth at bedtime for depression, Trazadone 200 mg (an antidepressant medication) by mouth at bedtime for depression, and Sertraline 50 mg (an antidepressant medication) by mouth at bedtime for depression. A review of a pharmacy consultation report dated October 14, 2024 completed by the consultant facility pharmacist recommended a gradual dose reduction (GDR) of the residents Mirtazapine 7.5 mg antidepressant medication. The GDR request was declined by the RN nurse practitioner on October 17, 2024. The documented reasoning was resident recently hospitalized secondary to behavior against staff. A GDR is contraindicated. A review of a pharmacy consultation report dated November 15, 2024 completed by the consultant	F 0758		

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F 0758 SS=E	Continued from page 54 facility pharmacist recommended a gradual dose reduction (GDR) of the residents Trazadone antidepressant medication. The GDR request was declined by the physician assistant on November 19, 2024. The documented reasoning stated "Residents psych medications are managed by the consultant psychiatrist. Please defer to this physician for medication management". Further review of the pharmacy consultant report failed to include a resident specific rationale to justify the continued use of the multiple antidepressants in use for this resident. In addition, there was no documented evidence at the time of the survey to justify the concurrent use of multiple antidepressant medications for this resident. An interview with the Director of Nursing (DON), on December 11, 2024, at approximately 1:00 PM, confirmed the facility failed to ensure that Resident 19's attending physician provided clinical	F 0758		

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F 0758 SS=E	Continued from page 55 justification/rationale for the continued administration of antidepressant medication and the concurrent use of multiple antidepressant medications. 28 Pa. Code 211.9 (k) Pharmacy services. 28 Pa. Code 211.12 (c) Nursing services. 28 Pa. Code 211.2 (d)(3) Medical Director	F 0758		
F 0842 SS=E		F 0842		

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F 0842 SS=E	Continued from page 56 483.20(f)(5), 483.70(h)(1)-(5) Resident Records - Identifiable Information §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(h) Medical records. §483.70(h)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(h)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;	F 0842	Resident 18 is deceased and resident 19 dementia care plan has been added. To identify other residents with the potential to be affected, the DON/designee completed an audit of all residents with dementia diagnosis to ensure care plan was developed and met residents individualized needs and care. To prevent this from re-occurring, the DON/designee educated the licensed nursing staff on dementia, specific individualized needs and plan of care. To monitor and maintain ongoing compliance, the DON/designee will audit new admissions with a diagnosis of dementia to confirm all care plans meet resident's individualized needs and care weekly then monthly x 2. All results will be brought to QAPI committee.	Completion Date: **01/09/2025** Status: **APPROVED** Date: **12/23/2024**

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 0842 SS=E	Continued from page 57 (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(h)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(h)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.	F 0842		

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F 0842 SS=E	Continued from page 58 This REQUIREMENT is not met as evidenced by:	F 0842		

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F 0842 SS=E	Continued from page 59 Based on clinical record review and staff interview, it was determined the facility failed to maintain accurate clinical records for one of 18 residents sampled (Resident 19). Findings include: A review of Resident 19's clinical record revealed the resident was admitted to the facility on July 5, 2022, with diagnoses that included acute dementia (a chronic condition that causes a decline in mental abilities, such as thinking, remembering, and reasoning, that interferes with daily life). A review of a care plan initiated July 18, 2022, for cognitive deficit revealed the resident has a diagnosis of Dementia with Lewy Bodies (Lewy body dementia causes a decline in mental abilities that gradually gets worse over time. People with Lewy body dementia might see things that aren't there. This is known as visual hallucinations. They also may have changes in alertness and attention).	F 0842		

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F 0842 SS=E	Continued from page 60 The facility was noted to have changed clinical record systems on April 8, 2024. The above noted care plan was not completely transferred, to include the dementia care plan for Resident 19, from the initial electronic medical record system to the system currently in use at the facility at the time of the survey ending December 12, 2024. During an interview conducted on December 11, 2024, 11:00 AM, the Director of Nursing (DON) confirmed that Resident 19's current care plan was incomplete. She stated that the facility changed electronic records systems on April 8, 2024, and all the resident medical information was not transferred from the prior electronic clinical records to the current system. The DON stated she did not know how many of the current residents at the time of the survey had complete medical records. 28 Pa Code 211.12(c)(d)(1)(3)(5) Nursing services	F 0842		

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F 0865 SS=E	483.75(a)(1)-(4)(b)(1)-(4)(f)(1)-(6)(h)(i) QAPI Prgm/Plan, Disclosure/Good Faith Attmpt §483.75(a) Quality assurance and performance improvement (QAPI) program. Each LTC facility, including a facility that is part of a multiunit chain, must develop, implement, and maintain an effective, comprehensive, data-driven QAPI program that focuses on indicators of the outcomes of care and quality of life. The facility must: §483.75(a)(1) Maintain documentation and demonstrate evidence of its ongoing QAPI program that meets the requirements of this section. This may include but is not limited to systems and reports demonstrating systematic identification, reporting, investigation, analysis, and prevention of adverse events; and documentation demonstrating the development, implementation, and evaluation of corrective actions or performance improvement activities; §483.75(a)(2) Present its QAPI plan to the State Survey Agency no later than 1 year after the promulgation of this regulation; §483.75(a)(3) Present its QAPI plan to a State Survey Agency or Federal surveyor at each annual recertification survey and upon request during any other survey and to CMS upon request; and §483.75(a)(4) Present documentation and evidence of its ongoing QAPI program's implementation and the facility's compliance with requirements to a State Survey Agency,	F 0865	Resident 19's clinical record is complete. To identify other residents that have the potential to be affected facility will complete an audit to ensure all medical records are complete. To prevent from re-occurring the contracted medical records consultant will educate medical records personnel on complete chart requirements. To monitor and maintain compliance the medical records/designee will audit new admissions weekly x 4 and monthly x 2 to ensure records are complete. All results will be brought to QAPI committee.	Completion Date: **01/09/2025** Status: **APPROVED** Date: **12/23/2024**

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F 0865 SS=E	Continued from page 62 Federal surveyor or CMS upon request. §483.75(b) Program design and scope. A facility must design its QAPI program to be ongoing, comprehensive, and to address the full range of care and services provided by the facility. It must: §483.75(b)(1) Address all systems of care and management practices; §483.75(b)(2) Include clinical care, quality of life, and resident choice; §483.75(b)(3) Utilize the best available evidence to define and measure indicators of quality and facility goals that reflect processes of care and facility operations that have been shown to be predictive of desired outcomes for residents of a SNF or NF. §483.75(b) (4) Reflect the complexities, unique care, and services that the facility provides. §483.75(f) Governance and leadership. The governing body and/or executive leadership (or organized group or individual who assumes full legal authority and responsibility for operation of the facility) is responsible and accountable for ensuring that: §483.75(f)(1) An ongoing QAPI program is defined, implemented, and maintained and addresses identified	F 0865		

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 0865 SS=E	Continued from page 63 priorities. §483.75(f)(2) The QAPI program is sustained during transitions in leadership and staffing; §483.75(f)(3) The QAPI program is adequately resourced, including ensuring staff time, equipment, and technical training as needed; §483.75(f)(4) The QAPI program identifies and prioritizes problems and opportunities that reflect organizational process, functions, and services provided to residents based on performance indicator data, and resident and staff input, and other information. §483.75(f)(5) Corrective actions address gaps in systems, and are evaluated for effectiveness; and §483.75(f)(6) Clear expectations are set around safety, quality, rights, choice, and respect. §483.75(h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. §483.75(i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.	F 0865		

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F 0865 SS=E	Continued from page 64 This REQUIREMENT is not met as evidenced by:	F 0865		

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F 0865 SS=E	Continued from page 65 Based on a review clinical records and facility provided documents it was determined the facility failed to develop and implement a quality assurance plan, which was able to identify, and correct ongoing quality deficiencies related to complete and accurate medical records. Findings include: A review of a facility policy for Quality Assurance and Performance Improvement (QAPI) program reviewed December 4, 2024, revealed the purpose of QAPI in the facility is to take a proactive approach to continually improving delivery of care and services and to engage residents, caregivers, and other clinical/operational partners in maximizing quality of life and quality of care. The facility will conduct performance improvement projects to examine and improve care and services which have been identified as opportunities for improvement.	F 0865		

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 0865 SS=E	Continued from page 66 A review of Resident 19's clinical record revealed the resident was admitted to the facility on July 5, 2022, with diagnoses that included acute dementia (a chronic condition that causes a decline in mental abilities, such as thinking, remembering, and reasoning, that interferes with daily life). A review of a care plan initiated July 18, 2022 for cognitive deficit indicated the resident has a diagnosis of Dementia with Lewy Bodies (Lewy body dementia causes a decline in mental abilities that gradually gets worse over time. People with Lewy body dementia might see things that aren't there. This is known as visual hallucinations. They also may have changes in alertness and attention). The facility was noted to have changed clinical record systems on April 8, 2024. The above noted care plan was not completely transferred, to include the dementia care plan for Resident 19, from the initial electronic medical record system to the system currently in use at the facility at the time of the survey ending December 12, 2024.	F 0865		

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F 0865 SS=E	Continued from page 67 During an interview conducted on December 11, 2024, 11:00 AM, the Director of Nursing (DON) confirmed that Resident 19's current care plan was incomplete. She stated that the facility changed electronic records systems on April 8, 2024 and all the resident medical information was not transferred from the prior electronic clinical records to the current system. The DON stated she did not know how many of the current residents at the time of the survey had complete medical records. During an interview December 12, 2024, the DON and NHA confirmed the ongoing issue regarding the transfer of medical records into the current electronic medical record was not part of the ongoing quality assurance program at the facility. The facility's quality assurance monitoring plans designed to ensure solutions were sustained, failed to identify the continuing deficient practice with these quality requirements and prevent deficient practice.	F 0865		

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F 0865 SS=E	Continued from page 68 Refer F744, F842 28 Pa. Code 211.12(c) Nursing services 28 Pa. Code 201.18(e)(1) Management	F 0865		
F 0880 SS=E	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards;	F 0880	Resident 56 skin check is current. Resident CR1 deceased. To identify residents with potential to be affected DON/designee will audit residents to ensure skin observations are current and issues identified will be addressed. To prevent from re-occurring DON/designee will educate licensed nursing staff on skin assessment policy. To monitor and maintain compliance DON/designee will audit 5 residents weekly x 4 then monthly x 2 for current skin assessments. All results will be brought to QAPI committee.	Completion Date: **01/09/2025** Status: **APPROVED** Date: **12/23/2024**

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F 0880 SS=E	Continued from page 69 §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens.	F 0880		

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F 0880 SS=E	Continued from page 70 Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by:	F 0880		

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F 0880 SS=E	Continued from page 71 Based on observations, review of the facility's infection control tracking logs, the infection control and prevention policy, and staff interviews it was determined the facility failed to develop and implement a comprehensive infection control program to prevent the spread of infectious diseases including scabies for two of 18 residents reviewed (Resident 56 and Resident CR1). Findings include: A review of the current facility policy for Infection Prevention and Control, last reviewed December 4, 2024, revealed it is the policy of the facility to maintain an organized, effective facility-wide program designed to systematically prevent, identify, control and reduce the risk of acquiring and transmitting infections among employees, volunteers, visitors and contract healthcare workers, to conduct surveillance of communicable disease and infectious outbreaks and to monitor employee health. A review of a facility policy entitled Scabies	F 0880		

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F 0880 SS=E	Continued from page 72 Management reviewed December 4, 2024, revealed, the purpose of the policy is to treat residents infected with and sensitized to scabies and to prevent the spread of scabies to other residents and staff. Affected residents should remain in contact precautions until 24 hours after treatment. Exposed staff members should report any rashes developing on their bodies to the Infection Preventionist or DON (Director of Nursing). A resident sharing a room with someone infected with scabies will be monitored for scabies. If symptoms are not present, daily assessments will occur until the case is resolved. Clinical record review revealed that Resident 56 was admitted to the facility on May 14, 2024, with diagnoses to include heart failure, hypertension (high blood pressure), and anxiety. A quarterly MDS assessment (Minimum Data Set - a federally mandated standardized assessment	F 0880		

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F 0880 SS=E	Continued from page 73 conducted at specific intervals to plan resident care) dated September 2, 2024, revealed the resident to be moderately cognitively impaired with a BIMS (Brief Interview for Mental Status, a short cognitive screening tool used to assess a person's cognitive functioning) score of 12 (a score of 8 to 12 suggests moderate cognitive impairment) and required staff assistance for activities of daily living. A review of a care plan initiated October 29, 2024 for skin integrity revealed the resident had a rash related to scabies with interventions to include, conduct a systematic skin inspection per facility policy, dermatology consult as needed, discourage resident from scratching area to reduce tissue damage, encourage resident to request medication before symptoms become unbearable, record the location, size (length, width, and depth), color, distribution, contour, consistency of rash(s) per facility policy, and monitor, document, and report to the provider any changes in color, temperature, sensation, pain or presence of drainage and/ or odor.	F 0880		

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F 0880 SS=E	Continued from page 74 A review of nursing notes dated September 19, 2024, at 7:50 P.M. revealed the resident's daughter reported Resident 56 had a small rash on her upper right arm, and a small red area was noted. The Resident was noted to be scratching at the area. The rash was cleansed with soap and water. A note was left for the physician to examine the resident. There was no documented nursing skin assessment completed at that time. A review of nursing progress note dated September 20, 2024, at 4:56 P.M. revealed the nurse practitioner was in to see the resident and address the family concerns of the itchy rash. A new order was noted for Hydrocortisone cream 1% (steroid cream) to the rash twice a day until resolved and then reassess. A review of a nursing progress note dated September 27, 2024, at 12:51 P.M. revealed the physician was in to see and examine the resident.	F 0880		

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F 0880 SS=E	Continued from page 75 The resident complained to the physician about an itchy rash to her right arm. New orders were noted to start a Medrol dose pack (oral steroids) and Clobetasol 0.05% cream (a medication used to treat skin conditions) twice a day for 5 days. A review of a skin assessment dated October 1, 2024 revealed, an existing skin issue noted, scab on lower mid back, with no redness. There was no documentation of a rash on the assessment form at that time. A review of a nursing progress note dated October 6, 2024, at 8:51 A.M. revealed the physician was in to see the resident and a new order was noted to start Claritin (oral allergy medication)10 mg by mouth, daily for itch and Betamethasone (topical steroid cream)0.05 topical ointment apply topically to affected areas twice daily. A review of a skin assessment dated October 8, 2024, revealed, an existing skin issue noted. Scratches on lower mid back/ sacrum with no	F 0880		

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F 0880 SS=E	Continued from page 76 redness or drainage. There was no documentation of a rash on the assessment form at that time. A review of a nursing progress note dated October 16, 2024, at 2:17 P.M. indicated the nurse practitioner saw the resident and discontinued the Claritin and wrote a new order to start Allegra (an oral allergy medication) 180 mg PO (by mouth) daily. A review of a skin assessment dated October 16, 2024 revealed, an existing skin issue noted, dermatitis throughout the resident's body with mid back and sacrum scratches. A review of a skin assessment dated October 22, 2024 revealed, an existing skin issue noted, scratches on the lower mid back and sacrum. No redness or drainage. Small red itchy bumps noted over te resident's entire body. A review of a psychiatry note dated October 28, 2024, 8:24 A.M. by the contracted nurse	F 0880		

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F 0880 SS=E	Continued from page 77 practitioner stated the resident was seen for a follow up psychiatry visit. The resident stated that her mood is "frustrated". The resident spoke in depth regarding her rash and management by her attending physician and lack of sleep. The resident reported anxiety related to her current situation. A nursing note dated October 28, 2024, at 11:48 A.M. revealed, a call was placed to dermatology and an appointment was scheduled for October 29, 2024 at 9:00 A.M. A nursing note dated October 29, 2024, at 10:34 A.M. revealed the resident returned from the dermatology appointment with diagnosis of scabies. A new order was noted to discontinue the Betamethasone (steroid cream) cream and to start Permethrin (anti-scabies treatment) cream apply topically from head to toe when sent from pharmacy, wash off in shower 12 hours post application, maintain contact precautions. Further recommendations included, clothing and bedding should be washed in hot water and any roommate	F 0880		

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F 0880 SS=E	Continued from page 78 should be treated for possible scabies. Clinical record review revealed that Resident CR1 was admitted to the facility on October 9, 2024, with diagnosis to include after care for a fracture (broken bone) and non-Hodgkin lymphoma (cancer). Resident CR1 and Resident 56 were roommates since Resident CR1's admission to the facility. There was no evidence that after the October 29, 2024, dermatology consultation that Resident CR1 or her responsible party were notified of the diagnosis of scabies and offered treatment as recommended by the dermatology office. A review of nursing documentation dated November 4, 2024 at 11:28 A.M. revealed nursing assessed the resident's skin fully. The resident had small areas where a rash remained. Multiple self-inflicted scratch marks were noted to bottom and top of the arms where there was no rash. The resident still complained of itching.	F 0880		

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F 0880 SS=E	Continued from page 79 A nurses note dated November 4, 2024 at 4:03 P.M. revealed the physician was called regarding the resident's itching and a new order was noted for Benadryl (an allergy medication) 25mg by mouth every 6 hours as needed for 1 week. A nurses note dated November 4, 2024, at 9:28 P.M. revealed the resident was upset rolling up and down halls and day room cursing at staff about medicines, other residents, her medical records, and food. The resident was unwilling/unable to articulate what was bothering her. Staff asked the resident to please refrain from bad language in public areas. The resident was offered Benadryl for itching, snacks, and drinks. Further the resident indicated she wants a lawyer to make her itching stop. A review of a skin assessment dated November 5, 2024, revealed, an existing skin issue noted, scratches on lower mid back, pimple-like area to right scapula, a rash to right mid back and flank area, and a rash to the right breast and under the	F 0880		

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F 0880 SS=E	Continued from page 80 right breast. There were no measurements for the noted areas or any additional description of the areas. A nurses note dated November 5, 2024, at 1:28 P.M. indicated dermatology was called regarding the resident's continued complaints of itching, informed of new areas of concern. A new order was noted to start Betamethasone (steroid cream) ointment twice a day. A nursing progress note dated November 5, 2024, at 10:35 P.M. revealed the second dose of permethrin cream was applied and was scheduled to be washed off in the morning. A nurses note dated November 12, 2024, at 1:43 P.M. revealed, the resident was assessed with nursing and physician assistant. A new order noted for Caladryl (anti itch lotion) three times a day and make a follow up appointment with dermatology. A nurses note dated November 13, 2024, at 2:26	F 0880		

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F 0880 SS=E	Continued from page 81 P.M. revealed the resident returned from the dermatology appointment with new orders for Ivermectin (an oral anti scabies medication) 3 mg, take 4 tablets by mouth on day 1 and repeat 14 days later. A review of a dermatology consultation report dated November 13, 2024, revealed the resident was seen for a follow up visit for scabies. The areas affected were noted as the arms, abdomen, back, buttocks, breast, chest, and legs. The areas were noted as worsened. The physician's findings included small papules and burrows with scales, excoriations, and crust located on the arms, breasts, abdomen, back and buttocks. Another two applications of the Permethrin cream was ordered at that time. There was no evidence at the time of the survey that comprehensive and accurate skin assessments were completed for Resident 56 with symptoms displayed since September 19, 2024 to the survey ending December 12, 2024.	F 0880		

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F 0880 SS=E	Continued from page 82 An interview with the ADON on November 11, 2024, at approximately 1:00 PM verified the facility failed to implement proper infection control practices, including the facility's established policy and procedures for skin assessments to prevent and mitigate further spread of scabies. 28 Pa Code 211.12 (d)(1)(2)(3)(5) Nursing Services 28 Pa. Code 201.18 (b)(1)(e)(1) Management	F 0880		

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P 1020	Responsibility of licensee. (a) The licensee is responsible for meeting the minimum standards for the operation of a facility as set forth by the Department and by other Federal, State and local agencies responsible for the health and welfare of residents. This includes complying with all applicable Federal and State laws, and rules, regulations and orders issued by the Department and other Federal, State or local agencies. This REGULATION is not met as evidenced by:	P 1020	PA-PSRS is now current. To identify residents with the potential to be affected DON/designee will complete and audit of the last 30 days of the requirements of ACT52 to ensure requirements are met. To prevent from re-occurring DON/designee will educate ADON/IP on requirements of ACT52. To monitor and maintain compliance DON/designee will audit submission of data to PA-PSRS monthly x 4 to ensure requirements are met. All results will be brought to QAPI committee.	Completion Date: **01/09/2025** Status: **APPROVED** Date: **12/23/2024**

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395567	A. BLDG: 00 B. WING:	12/12/2024

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P 1020	Continued from page 1 Based on staff interview and select facility policy review, it was determined the facility did not comply with the requirements of the Act 52 Infection control plan. Findings include: A review of the current facility policy for Infection prevention and control, last reviewed December 4, 2024, revealed, it is the policy of the facility to maintain an organized, effective facility-wide program designed to systematically prevent, identify, control and reduce the risk of acquiring and transmitting infections among employees, volunteers, visitors and contract healthcare workers, to conduct surveillance of communicable disease and infectious outbreaks and to monitor employee health. The infection prevention and control plan is comprehensive in that it addresses detection, prevention, and control of infections among residents and employees.	P 1020		

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P 1020	Continued from page 2 Act 52 Infection Control Plan, states that a health care facility should develop and implement an internal infection control plan that should be established for the purpose of improving the health and safety of residents and health care workers and should include a multidisciplinary committee. The multidisciplinary committee to include: (i) Medical staff that could include the chief medical officer or the nursing home medical director (ii) Administration representatives that could include the chief executive officer, the chief financial officer, or the nursing home administrator (iii) Laboratory personnel (iv) Nursing staff that could include a director of nursing or a nursing supervisor (v) Pharmacy staff that could include the chief of pharmacy (vi) Physical plant personnel (vii) A plant safety officer (viii) Members of the infection control team, which could include an epidemiologist (ix) The community, except that those	P 1020		

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P 1020	Continued from page 3 representatives may not be an agent, employee or contractor of the health care facility. In addition, the Act requires effective measures for the detection, control and prevention of health care-associated infections, culture surveillance processes and policies, procedures and protocols for staff who may have potential exposure to a resident known to be colonized or infected with MRSA (methicillin resistant staph aureus, a bacteria resistant to many antibiotics) or MDRO (multi-drug resistant organisms, which are common bacteria (germs) that have developed resistance to multiple types of antibiotics), an outreach process for notifying a receiving health care facility of any resident known to be colonized prior to transfer to another facility, a required infection-control intervention protocol, the procedure for distribution of advisories issued under section 405(b)(4) to staff in the facility, notification to facility staff of the infection control plan, documentation of the facility infection control reporting to PA-PSRS (Patient Safety Reporting System) and written reports,	P 1020		

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P 1020	Continued from page 4 documentation of notification of the serious event(infection) to the resident or responsible party. There was no evidence at the time of the survey the facility complied with the requirements of ACT 52. During interview on December 11, 2024, at 1:00 PM, the infection Preventionist confirmed the facility's current infection control policy and procedure in place at the time of the survey did not include all requirements of Act 52. She further confirmed that no infections were reported to the state reporting agency in regards to Act 52 since May 2024.	P 1020		
P 1210		P 1210		

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P 1210	Continued from page 5 Management. (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. This REGULATION is not met as evidenced by:	P 1210	Resident 84 discharged. To identify residents with the potential to be affected medical records personnel will audit all current residents to ensure that a current inventory sheet is in the medical record. To prevent from re-occurring the DON/designee will educate nursing staff on inventory sheet policy. To monitor and maintain compliance medical records will audit new admissions weekly x 4 and monthly x 2 to ensure inventory sheets are complete. All results will be brought QAPI committee.	Completion Date: **01/09/2025** Status: **APPROVED** Date: **12/23/2024**

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P 1210	Continued from page 6 Based on the review of clinical records and staff interviews, it was determined the facility failed to maintain a complete and accurate record of a resident's personal possessions upon admission and discharge for one resident out of two closed records sampled (Resident 84). Findings included: A review of Resident 84's clinical record revealed the resident was admitted to the facility on September 5, 2024, and discharged from the facility on September 24, 2024. A review of Resident 84's closed clinical record failed to reveal that an inventory of the resident's personal belongings was completed for the resident or resident representative to sign upon admission and discharge to ensure her personal property was accurate. An interview with the Assistant Director of Nursing (ADON) on December 12, 2024, at approximately	P 1210		

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P 1210	Continued from page 7 10:30 AM, revealed that upon admission to the facility, nursing staff were to record all of a resident's personal property brought into the facility on an inventory sheet and upon discharge the resident or resident representative were to sign the inventory sheet to indicate that all personal property was accurate and discharged with the resident. The ADON confirmed the facility was unable to provide documented evidence the facility completed an inventory record for Resident 84's personal property upon admission and unable to ensure accurate accountability for the resident's personal belongings.	P 1210		
P 5280		P 5280		

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P 5280	Continued from page 8 Pharmacy services. (j.1) The facility shall have written policies and procedures for the disposition of medications that address all of the following: (1) Timely and safe identification and removal of medications for disposition. (2) Identification of storage methods for medications awaiting final disposition. (3) Control and accountability of medications awaiting final disposition consistent with standards of practice. (4) Documentation of actual disposition of medications to include the name of the individual disposing of the medication, the name of the resident, the name of the medication, the strength of the medication, the prescription number if applicable, the quantity of medication and the date of disposition. (5) A method of disposition to prevent diversion or accidental exposure consistent with applicable Federal and State requirements, local ordinances and standards of practice. This REGULATION is not met as evidenced by:	P 5280	Resident 84 has been discharged. To identify residents with the potential to be affected DON/designee will audit discharges within the last 5 days to ensure medication dispositions are complete. To prevent from re-occurring the DON/designee will educate licensed nursing staff on medication destruction/return process. To monitor and maintain compliance the DON/designee will audit 5 discontinued/returned medications weekly x4 then monthly x 2. All results will be brought to QAPI committee.	Completion Date: **01/09/2025** Status: **APPROVED** Date: **12/23/2024**

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P 5280	Continued from page 9 Based on review of closed clinical records and select facility policy and staff interview, it was determined the facility failed to account for the disposition of medications upon discharge for one resident out of three closed records sampled (Resident 84). Findings include: A review of current facility policy entitled Disposition of Medications Upon Discharge last reviewed by the facility on December 2, 2024, indicated it was the facility's policy that upon discharge or leave of absence from the facility, the resident's medications shall be immediately removed from the medication cart and unused medications shall be disposed. The method of disposition and quantity of the drugs shall be documented on the respective resident's chart on the Medication Disposition/Destruction Form. A review of Resident 84's clinical record revealed the resident was admitted to the facility on	P 5280		

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P 5280	Continued from page 10 September 5, 2024, and discharged from the facility on September 24, 2024. There was no documented evidence the facility accounted for the disposition or quantity of any remaining medications upon the resident's discharge. Interview with the Director of Nursing (DON) on December 12, 2024, at 10:33 AM, confirmed there was no documented evidence of the accounting and disposition for the Resident 84's remaining medications.	P 5280		

Certified End Page

DUNMORE HEALTH CARE CENTER

STATE LICENSE NUMBER: 120902

SURVEY EXIT DATE: 12/12/2024

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