STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395260	A. Building B. Wing	07/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Carbondale Nursing and Rehabilitation Center	10 Hart Place Carbondale, PA 18407

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 39929 Based on a review of the facility's abuse prohibition policy and employee personnel files and staff interviews, it was determined that the facility failed to fully develop and implement established abuse prohibition procedures for screening five of five employees for employment (Employee 1, 2, 3,4 and 5) Findings include: According to regulatory requirements under SS483.12(a)(3) and 483.12(b)(1)] the facility must have written procedures for screening for prospective employees, to include reviewing: the employment history (e.g., dates of employment position or title), particularly where there is a pattern of inconsistency; information from former employers, whether favorable or unfavorable; and/or documentation of status and any disciplinary actions from licensing or registration boards and other registries. A review of the facility's Resident Abuse policy last reviewed by the facility January 3, 2023, revealed no procedures for screening potential employees that included obtaining references from current/previous employers. Review of employee personnel files revealed that Employee 1 (Registered Nurse) was hired March 14, 2024. The employee's application indicated that she had previous employers. There was no indication that the facility had contacted any of the employee's previous employers. Review of employee personnel files revealed that Employee 2 (unit aide) was hired April 16, 2024. The employee's application indicated that she had previous employers. There was no indication that the facility obtained information from former employers. Review of employee personnel files revealed that Employee 3 (LPN) was hired April 15, 2024. The employee's application indicated that she had previous employers. There was no indication that the facility obtained information from former employers. Review of employee personnel files revealed that Employee 4 (NA) was hired June 4, 2024. The employee's application indicated that she had previous employers. There was no indication that the facility obtained information from any former employers. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of employee personnel files revealed that Employee 5 (unit aide) was hired May 2, 2024. The employee's application indicated that she had previous employers. There was no indication that the facility obtained information from the former employers Interview with the Administrator on July 12, 2024, at 12:15 p.m. the NHA verified that there was no evidence that previous employers were contacted for information regarding the employees past employment. 28 Pa. Code 201.18 (e)(1) Management 28 Pa. Code 201.29 (a)(c)Resident Rights 28 Pa. Code 201.14(a) Responsibility of Licensee 28 Pa. Code 201.19 (1) Personnel records

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition 41581 Based on a review of clinical records and the Resident Assessment Instrument and staff interviews, it was determined that the facility failed to conduct a significant change Minimum Data Set Assessments (MDS - a federally mandated standardized assessment process conducted at specific intervals to plan resident care) for one of 21 residents reviewed (Resident 90). Findings include: According to the RAI User's Manual dated October 2023 a Significant Change in Status MDS assessment is required within 14 days of the determination of the significant change when: A resident enrolls in a hospice program; or A resident changes hospice providers and remains in the facility; or A resident receiving hospice services discontinues those services; or A resident experiences a consistent pattern of changes, with either two or more areas of decline or two or more areas of improvement, from baseline (as indicated by comparison of the resident's current status to the most recent CMS-required MDS). A review of the clinical record of Resident 90 revealed that the resident had experienced a significant decline in condition and was placed on Hospice Care (a type of care and philosophy of care that focuses on the palliation of a chronically ill, terminally ill or seriously ill patient's pain and symptoms, attending to their emotional and spiritual needs) on May 6, 2024. There was no documented evidence that a significant change MDS was completed to reflect that Resident 90's hospice services were initiated. Interview with the Nursing Home Administrator on July 12, 2024, at approximately 1:45 PM confirmed that a comprehensive significant change MDS assessment was not completed as required.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. 41581 Based on observations, clinical record review and staff and resident interview it was determined that the facility failed to ensure the ready availability of necessary emergency supplies for a resident receiving hemodialysis for one of 21 residents sampled. (Resident 52) Findings include: According to the National Kidney Foundation patients receiving hemodialysis (a machine filters wastes, salts and fluid from your blood when your kidneys are no longer healthy enough to do this work adequately) should keep emergency care supplies on hand. A review of Resident 52's clinical record revealed that the resident was admitted to the facility was on May 11, 2017, with diagnoses that included end stage renal disease and dependence on renal dialysis. Review of the resident's current plan of care, dated October 8, 2021, revealed that the resident required dialysis related to renal failure along with a care planned approach to have 4 x 4 gauze pads and cloth tape were to be at the bedside. Observations conducted on July 11, 2024, at 10:17 AM revealed no emergency supplies were available in the resident's room. Observations of the resident on July 11, 2024, at 10:20 AM revealed no emergency supplies were present on her wheelchair. An interview with Resident 52 on July 11, 2024, at 10:20 AM revealed that the resident stated that no emergency supplies for her dialysis access site are kept in her room. The resident stated that she has never seen those supplies in her room. Interview with Employee 6, LPN (licensed practical nurse), on July 11, 2024, at approximately 10:25 confirmed there were no emergency supplies at the resident's bedside or on her wheelchair. Interview with the Nursing Home Administrator on July 12, 2024, at approximately 1:45 PM confirmed the facility failed to ensure the ready availability of necessary emergency supplies at the resident's bedside. 28 Pa. Code 211.12 (d)(3)(5) Nursing Services

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 26142 Based on a review of clinical records and staff interviews it was determined that the facility failed to ensure the presence of current documented clinical necessity of a resident's continued use of an psychotropic medication prescribed on an as needed basis for one resident out of five sampled (Resident 65). Findings included: A review of the clinical record revealed that Resident 65 had diagnoses of Parkinsons disease (a progressive neurological disease), dementia, and a history of falling. The resident was placed on Hospice services November 24, 2023, for end stage Parkinson's disease. The resident had a physician order dated January 9, 2024, for Haldol, an antipsychotic medication, 2 mg/ml, SL (sublingual, under the tongue), 1 ml, SL every 6 hours for anxiety/terminal agitation (a common symptom of dying, characterized by sudden agitation, anxiety, anger or confusion). There was no corresponding physicians documentation or any documentation from hospice staff of related to the resident's need for this newly added antipsychotic medication, and the resident's anxiety/terminal agitation. Prior to the addition of the Haldol to this resident's drug regimen, the had eight falls from his wheelchair, from October 17, 2023, through January 8, 2024, on one occasion sustaining injuries to his head. Following initiation of the Haldol, the resident incurred an additional fall from his wheelchair on January 18, 2024, and in response the resident's Haldol dosage was increased. A physician order dated January 24, 2024, was noted for Haldol 2 mg/1 ml, give 1.5 ml SL every 6 hours for terminal agitation due to end stage Parkinsons disease/anxiety. The resident again fell from his wheelchair on June 11, 2024, and fell from bed on June 12, 2024 from bed. A physician order dated June 12, 2024, was noted to again increase the Haldol 2 mg/1 ml, give 2 mg (1 ml) SL every 4 hours (around the clock). The pharmacist requested that the physician, attempt a gradual dose reduction (GDR) dated June 23, 2024, noting the resident's Haldol order was increased to 2 mg every 4 hours without physicians documentation of rationale. The physician responded to the pharmacy request dated June 24, 2024 stating, patient has increased episodes of agitation, increased behaviors and agitation regarding dementia and Parkinsons disease. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The physician progress notes did not address the resident's behaviors and corresponding Haldol usage. There was no hospice physician documentation regarding the increase in the resident's dosage of Haldol. Interview with the interim Director of Nursing on June 12, 2024, at 10 AM, confirmed that there was no physician documentation regarding the initiation of the antipsychotic medication Haldol 2 mg/1mg, 1 mg every 6 hours around the clock, a doseage increase to 1.5 ml every 6 hours around the clock and the increase in the dose to 2 ml every 4 hours around the clock to reflect its clinical necessity. 28 Pa. Code 211.2 (d)(3) Medical director 28 Pa. Code 211.9 (a)(1) Pharmacy services 28 Pa. Code 211.5 (f) Clinical records

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a plan that describes the process for conducting QAPI and QAA activities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26142 Based on review of select facility policy, clinical records, and incident reports and staff interviews, it was determined that the facility failed to demonstrate the implementation of ongoing QAPI programs, to include the use of systems for investigating and analyzing the root cause of adverse events, as evidenced by multiple falls incurred by one resident out of 18 sampled (Resident 65). Findings include: Review of the facility policy entitled Quality assessment and improvement plan last reviewed by the facility January 9, 2024 revealed that the facility is committed to incorporating the principles of Quality Assurance and performance Improvement (QAPI) into all aspects of the center work processes, services lines and departments. All staff and stakeholders are involved in QAPI to improve the quality of life and quality of care that out patients and residents experience. The process included: - The administrator directs the development and documentation of the center QAPI plan, including an annual QAPI calendar, and is responsible for development, maintenance and ongoing evaluation of an active and effective Quality Assurance Performance Improvement Committee. -The committee meets at least 10 times annually, preferably monthly, to monitor quality within the center, identify issues and develop and implement appropriate plans of action to correct identified quality issues. The responsibilities to include: -Assess, evaluate and identify potential improvement opportunities based on: -Current reviews of core systems -all current regulatory on-site assessments -Adverse events since the past meeting, including prevention opportunities, investigations and corrective actions. A review of the clinical record revealed that Resident 65 was admitted to the facility on [DATE], with diagnoses to include Parkinsons disease (a progressive neurological disease), dementia, and a history of falling. The resident was placed on Hospice services November 24, 2023, for end stage Parkinsons disease. (continued on next page)

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The resident's baseline care plan, initiated February 27, 2023, revealed that Resident 65 had a history of falling prior to admission to the facility and impaired cognitive function related to Parkinson's disease and dementia with moderate, cognitive function. According to the resident's care plan the resident was at risk for falls related to his diagnosis of Dementia and Parkinson's disease. The resident's care plan indicated that the resident used a wheelchair for mobility and self-propelled throughout the facility as desired. A quarterly minimum data set assessment (Minimum Data Set - a federally mandated standardized assessment conducted at specific intervals to plan resident care) dated September 22, 2023, revealed the resident was moderately cognitively impaired, required staff assistance for activities of daily living and had a history of falling. A review of incident reports revealed that Resident 65 fell while leaning forward in his wheelchair, on the following occassions: -October 17, 2023, at 8:45 PM leaned foreward in his wheelchair and fell , sustaining a right forehead laceration -November 1, 2023, at 1:45 AM leaned foreward in his wheelchair and fell , sustaining an abrasion on his left forehead -November 17, 2023, at 7:45 AM leaned foreward in his wheelchair and fell , sustaining an abrasion on his left lateral forehead -November 17, 2023, at 5:49 AM leaned foreward in his wheelchair and fell , hitting his forehead on the floor. Staff placed him back into his wheelchair and he hit his head a second time on the door, sustaining an abrasion to his mid forehead, and a left frontal scalp abrasion. He was taken to the hospital and admitted with a left frontal scalp hematoma and a lumbar 1 fracture. -November 22, 2023, at 8:10 PM leaned foreward in his wheelchair and fell , sustaining an abrasion to his mid forehead with swelling -December 7, 2023, at 3:30 P.M., leaned foreward in the wheelchair, falling onto his forehead, receiving an abrasion to his mid forehead and bridge of his nose -December 10, 2023 at 4 PM leaned foreward in the wheelchair and fell , sustaining an abrasion to the left temple area with bleeding noted. -January 8, 2024, at 9:15 AM he leaned foreward in his wheelchair and fell , sustaining an abrasion to his forehead. -January 18, 2024 at 6 PM he leaned foreward in his wheelchair and fell , foreward, sustaining a bloody nose and a laceration above his left eye -June 11, 2024 at 5:54 PM stood up from the wheelchair, he leaned towards his left side and fell . (continued on next page)

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of occupational therapy (OT) notes indicated that the resident was referred to OT with services rendered from September 16, 2023, through October 20, 2023 related to repeated falls from his wheelchair. An OT encounter note dated October 2, 2023, indicated that OT continued to trial the resident in a standard wheelchair with foam cushion and right lateral support. During observation, patient participated in therapy tasks, however, when pieces dropped onto the floor, patient attempting to reach down to pick up but this position does place patient at risk for falling. Patient required cues to adjust posture when he sat back up due to leaning over to the right side. At this time, patient may need direct supervision when he is positioning in standard wheelchair. OT discharge documentation dated October 20, 2023, indicated that the resident was noted to propel in the standard wheelchair with the use of his bilateral lower extremities. With propulsion, the resident continues to lean forward in attempt to gain momentum to move the chair. The resident had multiple falls after this therapy period as noted above. The resident fell from his wheelchair, leaning out of the chair November 17, 2023, twice with resulting injuries of a scalp hematoma and lumbar one fracture. The planned intervention following this fall with injury was to refer him to therapy to reassess his wheelchair seating. A review of occupational therapy notes revealed that Resident 65 received OT services from November 21, 2023, through December 8, 2023. OT documentation dated November 21, 2023 revealed Resident provided with training for wheelchair propulsion. He was able to follow verbal cues to maintain upright trunk position throughout and will correct same when told to do so. Resident present for a two hour period. While not directly working with the therapist, the resident was given a variety of activities intermittently including, exercises, games, and newspaper and displayed no behavioral issues and no attempts to self transfer. The Director of Rehab consulted with the facility Director of Nursing discussing therapy and the need for an interdisciplinary team approach to addressing and managing his falls. Incident reports revealed that the the resident continued to fall through December 2023 and January 2024. Occupational therapy for wheelchair seating was again ordered as an intervention, January 10, 2024 through January 20, 2024. The resident had an additional fall January 18, 2024. and again June 11, 2024, while leaning foreward from the wheelchair. The facility to demonstrate that their QAPI system had attempted to identify and effectively address the underlying cause or contributing factors to these repeated falls to timely initiate effective interventions in an effort to prevent recurrent falls of a similar nature. During an interview July 11, 2024 at approximately 2 P.M., the Nursing Home Administrator stated that the facility could not provide additional supervision of the resident as an fall prevention intervention to prevent multiple falls, and resultant head injuries and fractured lumbar one bone. (continued on next page)

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	At the time of the survey ending June 12, 2024, the facility had not yet effectively addressed the resident's behavior of leaning forward in his wheelchair, which had resulted in multiple falls and facial injuries. There was no evidence at the time of the survey that the facility demonstrated an effective QAPI program to include evaluating outcomes, quality of care and quality of life by investigating adverse incidents and evidence of maintenance of thorough documentation to support their analysis of the data collected and any corrective actions developed and implemented. 28 Pa. Code 201.18 (b)(1)(3)(e)(1)(4) Management 28 Pa. Code 211.12 (c) Nursing Services