STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395344	A. Building B. Wing	03/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pottsville Rehabilitation and Nursing Center	420 Pulaski Drive Pottsville, PA 17901

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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39929 Based on a review of select facility policy, clinical records and select facility reports and interviews with staff, it was determined that the facility failed to ensure that one out of seven residents reviewed was free from physical abuse (Resident 1) perpetrated by another resident (Resident 2), which resulted in actual harm of a fractured wrist to Resident 1. Findings include: A review of the current facility policy titled Abuse Policy reviewed by the facility December 2022, revealed that residents have the right to be free from abuse, neglect, misappropriation of property, corporal punishment, and involuntary seclusion, noting that No abuse or harm of any type will be tolerated. A review of Resident 2's clinical record revealed that the resident was admitted to the facility on [DATE], with diagnoses, which included alzheimer's disease (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 quarterly Minimum Data Set assessment dated [DATE], indicated that the resident was severely cognitively impaired with a BIMS (brief interview for mental status - a tool to assess cognitive status) of 3. According to the MDS Section E. Behavior, Resident 2 displayed verbal behaviors such as threatening others, screaming at others, cursing at others on 1-3 days during the assessment look back period and had physical behaviors of kicking, biting, scratching at others, etc., 1-3 days of the assessment look back period. The clinical record revealed that due to previous incidents of resident to resident abuse, perpetrated by Resident 2 in the past recent months, Resident 2 was receiving 1-1 staff supervision while awake and 15-minute checks while sleeping at the time of the incident on February 14, 2023. A review of a facility investigation report dated February 14, 2023, at 2:30 p.m., revealed that Employee 1 (LPN) heard a resident yelling let go of my hand. When Employee 1 entered the dining room she observed Resident 2 standing next to Resident 1 with his hand around Resident 1's left hand. Resident 2 was asked what happened and he stated, I don't know, that was my seat. Both residents were assessed. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	A review of Resident 1's clinical record revealed that the resident was admitted to the facility on [DATE], with diagnoses, which included Alzheimer's disease (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 1's Quarterly Minimum Data Set assessment dated [DATE], revealed that the resident was severely cognitively impaired, with a BIMS score of 3. A review of information submitted by the facility and a facility incident investigation dated February 14, 2023, at 2:30 p.m., revealed that Employee 1 heard Resident 1 yell for help. Employee 1 was behind the nurses' station at that time, Employee 1, saw Resident 2 with his hand around Resident 1's left hand in the dining room. Resident 2 wanted Resident 1's seat and was squeezing Resident 1's hand. The residents were separated. Resident 1's hand swelled over the evening of February 14, 2023, and her physician ordered an x-ray. Results of an x-ray of Resident 1's left hand indicted a potential occult fracture of the distal cortical margin of the radius (wrist fracture). Resident 1 required a cast for two weeks. The facility reported that prior to the incident on February 14, 2023, Resident 2 was last seen sleeping and was not due to be checked on for another 5 minutes because the plan was to check the resident every 15 minutes while sleeping. A review of staffing for the day, February 14, 2023, of the incident revealed two LPNs and two CNAs were assigned to the resident's unit at time of the incident. Review of the facility incident report, including employee witness statements, revealed only two staff members were on the unit at the time of the incident as the other two employees were on lunch breaks, Employee 1 and Employee 2 (CNA). Employee 1 was behind the nurses station at the time of the incident. According to Employee 2's witness statement she was toileting another resident. There was no staff present in the dining room where there were multiple residents with dementia, left unsupervised according to the report. Resident 2's room is located at the end of the hallway farthest away from the dining room where the incident occurred. The facility failed to ensure that Resident 1 was free from physical abuse perpetrated by Resident 2, resulting in serious injury to Resident 1. An interview with the DON (director of nursing) and NHA (nursing home administrator) on March 29 2023, at approximately 2:00 p.m., confirmed that the facility substantiated physical abuse of Resident 1 by Resident 2. 483.13 - Resident Behavior and Facility Practices, 10-1-1998 edition 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18(e)(1) Management 28 Pa. Code 201.29(a) Resident Rights 28 Pa. Code 201.29(c)(d) Resident Rights (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	28 Pa. Code 211.12(a)(c)(d)(5) Nursing Services

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39929 Based on staff interviews and a review of clinical records and facility documentation, it was determined that the facility failed to ensure that residents dependent on staff for assistance with activities of daily living consistently received showers and bathing as planned to maintain good personal hygiene for four of seven residents sampled (Residents 5, 6, 1 and CR1). Findings included: Review of the current facility policy Shower/Bath provided during the survey of March 29, 2023, revealed that the facility will offer two shower or baths to each resident per week or per resident preference. A review of the clinical record revealed that Resident 5 was admitted to the facility on [DATE], with diagnoses to include Alzheimer's dementia, muscle weakness, abnormal posture, abnormalities of gait and need for personal assistance. A quarterly Minimum Data Set assessment (MDS- a federally mandated standardized assessment process conducted at specific intervals to plan a resident's care) dated February 22, 2023, revealed that the resident was severely impaired with a BIMS score of 3 (Brief Interview for Mental Status - a tool to assess cognitive function - a score of 0-7 indicates severe cognitive impairment), required physical help in part with bathing with one person physical assistance in order to take full-body bath/shower, sponge bath, and transfers in/out of tub/shower. Review of Resident 5's Documentation Survey Reports (direct care nursing tasks completed for the resident) dated February 2023 and March 2023, through the end of survey March 28, 2023, revealed that the resident was scheduled to receive a shower on day shift every Tuesday and Friday. The report noted that the resident refused a shower on February 3, February 14, February 17, February 28, March 7, March 14, March 21, March 24, and March 28, 2023. The report noted that the resident received a bed bath on March 24, 2023. There is no documented evidence that the resident was offered or provided a shower on another day of the week or during another shift to promote good personal hygiene. There was no documented evidence that the facility showered the resident twice each week as planned and according to facility policy. There was no documented evidence in the resident's clinical record or care plan of any resident refusals of personal or reasons for not showering this resident as scheduled or interventions planned in response to the resident's reported repeated refusals to be showered. A review of Resident 6's clinical record revealed she was admitted to the facility on [DATE], with diagnoses of abnormal posture, need for assistance with personal care and muscle weakness. A quarterly Minimum Data Set assessment (MDS), dated [DATE], revealed that the resident was not administered the BIMS. The bathing task activity itself did not occur and the ADL activity itself did not occur during the assessment period. The prior quarterly MDS dated [DATE], reports the resident's BIMS were not assessed, the bathing task was total dependence requiring one-person physical assist in order to take full-body bath/shower, sponge bath, and transfers in/out of tub/shower. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the Documentation Survey Reports dated February 2023 and March 2023 revealed that the resident preferred showers on Tuesday and Friday on day shift. According to these reports, the resident was not showered during the months of February 2023 and March 2023. Staff noted that a bed bath was provided on February 10, February 14, February 24, February 28, March 14, March 24 and March 28, 2023. This report indicates Resident 6 was bathed only four times in February 2023 and three times in March 2023. There was no documented evidence that the facility showered the resident twice each week as planned and according to facility policy. There was no documented evidence in the resident's clinical record or care plan of any resident refusals of personal care or reasons for not showering this resident as scheduled along with interventions to be implemented in response to the resident's reported repeated refusals to be showered. A review of Resident 1's clinical record revealed that the resident was admitted to the facility February 4, 2021, with diagnoses, which included dementia. Resident 1's quarterly Minimum Data Set Assessment (MDS - a federally mandated standardized assessment conducted at specific intervals to plan resident care) dated February 24, 2023, indicated that the resident required the assistance of one staff member for bathing/showers. The resident was cognitively impaired with a BIMS score of 6 (brief interview for mental status, a tool to assess the residents' attention, orientation, and ability to register and recall new information, a score of 6 indicates the resident is cognitively impaired). A review of the resident's February 2023 shower record revealed that Resident 1 was showered on February 9 and February 24, 2022. A review of the resident's March 1, through the end of survey ending March 29, 2023, shower record revealed the resident received two showers during the month of March, on March 9 and March 24, 2023. There was no documented evidence that the facility showered the resident twice each week as planned and according to facility policy. There was no documented evidence in the resident's clinical record or care plan of any resident refusals of personal hygiene care or reasons for not showering this resident as scheduled and interventions developed for staff use in response to any reported resident refusal to maintain good personal hygiene and grooming. A review of Resident CR1's clinical record revealed that the resident was admitted to the facility February 16, 2023, with diagnoses which included diabetes. Resident CR1's 5-day Medicare Minimum Data Set Assessment (MDS - a federally mandated standardized assessment conducted at specific intervals to plan resident care) dated February 22, 2023, indicated that the resident required the assistance of one staff member for bathing/showers. The resident was cognitively intact with a BIMS score of 14 (brief interview for mental status, a tool to assess the residents' attention, orientation, and ability to register and recall new information, a score of 14 indicates the resident is cognitively intact). A review of the resident's February 16, to her discharge February 23, 2023, shower record revealed that Resident CR1 was not showered during the resident's stay at the facility. (continued on next page)

Printed: 11/27/2024
Form Approved OMB
No. 0938-0391

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	There was no documented evidence that the facility showered the resident twice each week as planned and according to facility policy. There was no documented evidence in the resident's clinical record or care plan of any resident refusals or reasons for not showering this resident as scheduled. Interview with the Director of Nursing (DON) on March 29, 2023, at approximately 1:15 PM, confirmed that nursing staff are to document on the residents' shower record when a shower or bed bath are completed for each resident. 28 Pa. Code 201.29 (j) Resident rights 28 Pa. Code 211.11 (d) Resident care plan 28 Pa. Code 211.12 (a)(c)(d)(5) Nursing services. 28 Pa. Code 211.10(a)(d) Resident care policies