STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395101	A. Building B. Wing	03/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sayre Health Care Center	151 Keefer Lane Sayre, PA 18840

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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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 29512 Based on clinical record review and staff interview, it was determined that the facility failed to honor advance directive choices for one of 24 residents reviewed (Resident 175). Findings include: Clinical record review for Resident 175 revealed that on [DATE], the resident's responsible party indicated that the resident was a full code (staff was to start CPR [Cardiopulmonary Resuscitation]). On February 27, 2025, Resident 175's responsible party completed a POLST (Physician Orders for Life-Sustaining Treatment, a form directing medical staff to complete life-sustaining treatment or allow a natural death) form and a facility code status form (a form directing life-sustaining care) both which indicated Do Not Resuscitate (DNR) for Resident 175. Resident 175's code status form was also signed by the physician on February 27, 2025. There was no documentation that the facility changed Resident 175's code status order from full code to DNR until [DATE]. The above information was reviewed during an interview on [DATE], at 3:39 PM with the Nursing Home Administrator. 28 Pa. Code 201.29(c) Resident rights 28 Pa. Code 211.10(a) Resident care policies 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services

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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. 20725 Based on clinical record review and staff interview, it was determined that the facility failed to provide the required notification to a resident whose payment coverage changed for one of three residents reviewed (Resident 2). Findings include: A review of the form Instructions for the Notice of Medicare Non-Coverage (NOMNC) CMS-10123, (a notice that informs the recipient when care received from the skilled nursing facility is ending; and how to contact a Quality Improvement Organization (QIO) to appeal) revealed instructions that a Medicare provider must ensure that the notice is delivered at least two calendar days before Medicare covered services end. A review of the Form Instructions Skilled Nursing Facility (SNF) Advanced Beneficiary Notice of Non-coverage (SNFABN) Form CMS-10055 revealed that examples of the common reasons why an extended care stay, or services may not be covered under Medicare might include the beneficiary no longer requires daily skilled care for a medical condition but wants to continue residing in the skilled nursing facility (SNF). The SNF enters a good faith estimate of the cost of the corresponding care that may not be covered by Medicare. In the blank that follows Beginning on ., the skilled nursing facility enters the date on which the beneficiary may be responsible for paying for care that Medicare is not expected to cover. The beneficiary selects an option box to indicate a desire to continue to receive the care or not to continue to receive the care and if there is a desire to have the bill submitted to Medicare for consideration. The beneficiary or their authorized representative must sign the signature box to acknowledge that they read and understood the notice. The SNF must issue this notice when there is a termination of all Medicare Part A services for coverage reasons. If after issuing the NOMNC, the SNF expects the beneficiary to remain in the facility in a non-covered stay, the SNFABN must be issued to inform the beneficiary of potential liability for the non-covered stay. Clinical record review for Resident 2 revealed census information that Medicare payment for care ended July 26, 2024. Resident 2 remained in the facility. Review of a CMS-10123 form for Resident 2 confirmed that the last covered day of Medicare payment was July 26, 2024. There was no evidence that the facility provided a CMS-10055 form to Resident 2. Interview with the Nursing Home Administrator on March 7, 2025, at 12:00 PM confirmed that there was no additional evidence that Resident 2 received the CMS-10055 form after Medicare payment for her care stopped, but she remained in the facility. 483.10(g)(17)(18)(i)-(v) Medicaid/medicare Coverage/liability Notice Previously cited deficiency 4/19/24 28 Pa. Code 201.18(b)(2)(e)(1) Management (continued on next page)

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	28 Pa. Code 201.29(a) Resident rights

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 44738 Based on observation and staff interview, it was determined that the facility failed to provide a clean, comfortable, and homelike environment on one of two nursing units reviewed (Nursing Unit 2; Residents 24, 50, and 54). Findings include: Observation of Resident 24's room on March 4, 2025, at 12:54 PM; and March 7, 2025, at 12:45 PM revealed a six-foot section of wall located under the resident's window that had a large, black colored linear stain and marring in various areas. Observation with the Nursing Home Administrator (NHA) of an egress area leading outside to the laundry building on March 6, 2025, at 11:17 AM revealed multiple partially smoked cigarette butts discarded on the ground. A concurrent interview with the NHA revealed it was unclear who the cigarette butts belonged to since the facility is non-smoking. The above information for Resident 24's room and the egress area was reviewed in a meeting with the Nursing Home Administrator on March 7, 2025, at 12:38 PM. Observation of the Unit 2 Nursing Unit on the following dates and times revealed: On March 4, 2025, at 11:53 AM the drywall was marred on the lower corner of the wall to the left of Resident 50's bathroom. On March 4, 2025, at 12:30 PM the drywall was warred and gouged on the lower corner of the wall to the left of Resident 54's bathroom. On March 5, 2025, at 9:05 AM there were two fake leather love seats in the lounge near Unit 2 entrance. Both love seat's fake leather was significantly peeling on the seat cushions and arm rests with cloth showing underneath. On March 5, 2025, at 9:25 AM the drywall of Unit 2's dining room walls near the hallway and the door to the courtyard were gouged at both foot and table height. The above information was reviewed during an interview with the Nursing Home Administrator on March 5, 2025, at 2:15 PM. 28 Pa. Code 201.18(b)(3)(e)(2.1) Management

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 29512 Based on review of the facility policy, employee personnel records, and staff interview, it was determined that the facility failed to develop and implement an abuse prohibition policy that required a thorough investigation of prospective employee's employment history for one of five newly hired employees reviewed (Employee 7). Findings include: The policy entitled Abuse Policy and Procedure last reviewed without changes on June 13, 2024, revealed that the facility will protect the residents from abuse, neglect, misappropriation of resident property, corporal punishment and involuntary seclusion. The facility will not apply and employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law. All potential employees are screened for a history of abuse, neglect, and misappropriation of property by completing a state criminal background on all prospective employees and if not a resident of the state (where the facility was located) for two consecutive years, an FBI (Federal Bureau of Investigation) check will be conducted. Review of Employee 7's, cook, personnel record on March 7, 2025, revealed that the facility hired them on October 29, 2024, (129 days prior). Employee 7's personnel record revealed that she did not live in the same state as the facility location for more than two years. Further review of Employee 7's record did not reveal any evidence that the facility attempted to obtain or complete an FBI background check to determine criminal history for Employee 7. Interview with Employee 8, human resources, on March 7, 2025, at 10:45 AM and the Nursing Home Administrator on March 7, 2025, at 11:05 AM, revealed that the facility failed to complete the FBI background check within 90 days of employment and confirmed that Employee 7 provided services and access to residents since employed. 28 Pa. Code 201.18(b)(1)(3) Management 28 Pa. Code 201.19 Personnel policies and procedures 28 Pa. Code 201.29(a) Resident rights 28 Pa. Code 211.12(d)(1)(5) Nursing services

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 20725 Based on clinical record review and staff and resident interview, it was determined that the facility failed to develop and implement a comprehensive care plan for two of 18 residents reviewed (Residents 44 and 5). Findings include: Interview with Resident 44 on March 4, 2025, at 11:56 AM revealed that two staff provided her assistance to complete her most recent shower ,and they were, slam bam, with the shower care. Resident 44 denied that staff were abusive, but she confirmed that she did not appreciate the approach staff used when providing her care. Review of electronic Task Documentation (electronic system for nurse aides to document the provision of care) dated February 2025, revealed that Employee 3 (nurse aide) documented Resident 44 received a shower on Friday evening, February 28, 2025. Interview with Employee 3 on March 5, 2025, at 2:25 PM revealed that she remembered Resident 44's shower experience on February 28, 2025. Employee 3 stated that another nurse aide, Employee 6, asked her to witness Resident 44's shower care because Resident 44 was known to make false accusations against staff. Employee 3 stated that she witnessed Employee 6 begin to propel Resident 44 into the shower room via her wheelchair when Resident 44 began to get agitated stating that Employee 6 was hurting her shoulder (although Employee 6 had made no physical contact with Resident 44's body, only the handles of her wheelchair). Then Resident 44 began yelling at Employees 3 and 6 that they were going to damage her hearing aids in the shower although the hearing aids were in the charger in her room. Clinical record review for Resident 44 revealed a plan of care initiated on December 7, 2024, that Resident 44 had a right to refuse care. Interventions included instructions, If resident becomes agitated or combative remove yourself (sic) from resident and reattempt when at a later time when calmer, and Staff will re-approach resident at a later time. A plan of care initiated by the facility on December 16, 2024, due to Resident 44's trigger for cognitive loss due to noted behaviors listed interventions that included, Provide the resident with necessary cues, stop, and reapproach if agitated. The facility did not develop a care plan for Resident 44 that included an intervention that two staff should provide care due to her known behavior of false accusations. Staff failed to implement the interventions to stop care and reapproach Resident 44 when she exhibited agitated behaviors with false accusations. The surveyor reviewed the above concerns regarding Resident 44 during an interview with the Nursing Home Administrator and Employee 5 (director of rehab) on March 5, 2025, at 2:00 PM. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with Resident 5 on March 4, 2025, at 11:42 AM revealed the resident has an implanted pacemaker (a device implanted into the chest used to control the heartbeat). The resident also has a pacemaker transmitter device on the windowsill that is utilized to remotely monitor and transmit information from the resident's pacemaker. The resident further noted the device has an alarm that activates if there is an issue with the pacemaker or a tower is not close enough. Per the resident, the device has not alarmed since being at the facility. Medical provider documentation for Resident 5 dated March 1, 2025, at 7:52 PM noted the resident has a cardiac pacemaker. Interview with Employee 9, license practical nurse, on March 6, 2025, at 11:33 AM revealed that staff are to call the number located on the device if it would alarm. Employee 9 further noted that any additional information related to the device should be on the chart. Further review of the clinical record (both the electronic health record and the paper chart) for Resident 5 revealed no information related to the pacemaker monitoring/transmitting device. The facility provided a Quick Start Guide for the transmitter after questioning by the surveyor that included information such as: the transmitter should be no more than 10 feet from the bed, information on transmitting data such as the resident being within one foot of the device, not using a phone during transmission, positioning of the transmitter during sleep, and troubleshooting information. There was no care plan for Resident 5 that addressed care or precautions related to the pacemaker or the associated transmitting device. The facility later provided a care plan for Resident 5 that was dated as created and initiated on March 7, 2025, after discussion with the surveyor. Clinical record review for Resident 5 revealed the resident was currently on Eliquis (a medication that helps to prevent blood clots and stroke) 5 milligrams (mg) two times a day by mouth. Clinical record review for Resident 5 revealed no care plan related to the medication or evidence that the facility was monitoring the resident for side effects (such as bleeding) associated with the Eliquis. Further review of the clinical record for Resident 5 revealed an order dated March 7, 2025, at 10:26 AM, after discussion with the surveyor, to instruct staff to monitor for signs and symptoms of bleeding due to being on anticoagulant medication (a medication to help prevent blood clots). The facility also created a care plan related to anticoagulation therapy for Resident 5 that was initiated on March 7, 2025, after surveyor questioning. The above information for Resident 5 was reviewed with the Nursing Home Administrator on March 7, 2025, at 10:49 AM. 28 Pa. Code 211.12(d)(1)(5) Nursing services

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F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure necessary information is communicated to the resident, and receiving health care provider at the time of a planned discharge. 44738 Based on closed clinical record review and staff interview, it was determined that the facility failed to provide a discharge summary with the necessary components for one of three closed records reviewed (Resident CR1). Findings include: Closed clinical record review for Resident CR1 revealed nursing documentation dated January 6, 2025, at 4:28 PM that Resident CR1 was discharged to home with home health services. Further review of the closed clinical record for Resident CR1 revealed wound care documentation dated January 3, 2025, that noted the resident had a Stage 3 Pressure Ulcer (full-thickness loss of skin, in which subcutaneous fat may be visible in the ulcer and granulation tissue) to the sacrum (a bone at the base of the spinal column). Closed record review for Resident CR1 revealed a document titled, Resident Discharge Summary, dated January 6, 2025. The document was signed by the resident's responsible party and the discharging nurse. The discharge summary did not include anything about the resident's wound, consultation, or recommended treatment by wound care. The section titled Wound Care/Treatment was documented as, None. The facility failed to provide a discharge summary for Resident CR1 that contained a full recapitulation of the resident's stay that included, but is not limited to, diagnoses, course of illness, treatment, therapy, and pertinent lab, radiology, and consultation results. The above information for Resident CR1 was reviewed in a meeting with the Nursing Home Administrator on March 7, 2025, at 1:35 PM. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. 44738 Based on clinical record review and resident and staff interview, it was determined that the facility failed to provide care and services to maintain or improve the ability to perform activities of daily living for two of five residents reviewed for rehabilitation concerns (Residents 5 and 44). Findings include: An interview with Resident 5 on March 4, 2025, at 11:18 AM revealed that she has been doing her own exercises and is currently not in therapy. A review of the task documentation (located in the electronic health record where staff document specific care related events for a resident) for Resident 5 revealed a restorative nursing program (RNP) dated March 3, 2025, that noted the following: RNP Sit to Stands: with use of grab bars resident to come to a standing position, hold for a count of 10, and sit for 10. Nursing documentation for Resident 5 dated March 3, 2025, at 9:37 AM revealed the resident is starting on a new RNP program. An occupational therapy discharge summary for Resident 5 dated February 4, 2025, noted dates of service as October 22, 2024, to January 27, 2025. Discharge recommendations for functional maintenance included sit-to-stands at grab bars, assist x1, standing as tolerated. A physical therapy discharge summary for Resident 5 dated February 24, 2025, noted dates of service as October 22, 2024, to January 27, 2025. Discharge recommendations noted a restorative transfer program that included sit-to-stands at grab bars. Further review of the task documentation for Resident 5 revealed that staff had not documented any RNP exercises until March 3, 2025, despite a discharge date from therapy noted as January 27, 2025. An interview with Employee 5, Director of Therapy, on March 7, 2025, at 10:55 AM, with the Nursing Home Administrator present, confirmed that Resident 5 was discharged from therapy on January 27, 2025, and did not start the recommended restorative program until March 3, 2025, due to the program being missed. Interview with Resident 44 on March 4, 2025, at 12:01 PM revealed that she believed that she was advanced from routine skilled therapy services. Due to cognitive deficits, Resident 44 had difficulty expressing if nursing or skilled therapy (physical therapy or occupational therapy) staff performed exercises with her, just that she had, move up day (interpreted to mean discharged from skilled therapy to restorative nursing services). A physical therapy discharge summary dated February 26, 2025, indicated that Resident 44 reached her maximum potential ,and Resident 44 would remain in the facility with a restorative nursing program. The ambulation program would consist of Resident 44 ambulating up to 100 feet with the use of a roller walker and contact guard assistance. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 44's clinical record did not contain evidence of an active restorative nursing program. The surveyor requested evidence of a restorative nursing program completed with Resident 44 during an interview with the Nursing Home Administrator and Employee 5 on March 5, 2025, at 2:00 PM. Review of nurse aide task documentation dated March 2025, revealed that the facility initiated a restorative nursing program for Resident 44's ambulation (after the surveyor's questioning) on March 5, 2025. Review of a plan of care developed by the facility on December 6, 2024, to address Resident 44's self-care deficits revealed that the facility initiated the intervention for Resident 44's restorative nursing program for ambulation on March 5, 2025. Interview with the Nursing Home Administrator on March 7, 2025, at 9:30 AM confirmed that the facility did not initiate a restorative nursing program to maintain Resident 44's ambulation skills following the termination of skilled therapy services. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. 20725 Based on clinical record review and staff interview, it was determined that the facility failed to implement physician orders for two of 18 residents reviewed (Residents 52 and 21). Findings include: Clinical record review for Resident 52 revealed documentation by the facility's consultant optometrist (healthcare provider who specializes in eye care and vision services) dated January 21, 2025, that the provider evaluated Resident 52 for blurry vision in her right and left eyes. The provider diagnosed that Resident 52 had dry eye syndrome (tears are unable to provide adequate lubrication of the eye) of bilateral lacrimal glands (gland above the eye that produces tears), which was described as significant. The plan was to treat Resident 52 with one drop of artificial tears solution in both eyes twice a day. Resident 52's clinical record contained no evidence that staff implemented the eye care professional's directive to start artificial tears twice daily. Interview with the Nursing Home Administrator on March 7, 2025, at 9:22 AM confirmed that the facility failed to implement physician ordered artificial tears for Resident 52 following her appointment in January 2025. Clinical record review for Resident 21 revealed current physician orders for staff to obtain a daily weight. Review of Resident 21's weight documentation revealed that staff did not document their weight on the following dates: January 1, 5, 7, 15, 19, 24, and 26, 2025 February 1, 3, 4, 9, 17, 20, and 23, 2025 March 2, 2025 The above information during an interview on March 7, 2025, at 9:16 AM with the Nursing Home Administrator. 483.25 Quality of Care Previously cited deficiency 4/19/24 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44738 Based on closed clinical record review and staff interview, it was determined that the facility failed to provide recommended interventions, that are consistent with professional standards of practice, to promote healing of a pressure ulcer for one of two residents reviewed for pressure ulcers (Resident CR1). Findings include: Closed record review for Resident CR1 revealed the resident was admitted to the facility on [DATE]. The resident was discharged on [DATE]. Nursing documentation upon admission for Resident CR1 dated December 27, 2024, at 6:01 PM revealed the resident had a Skin tear one centimeter in size to sacrum (a bone at the base of the spine). An admission assessment for Resident CR1 titled Admit/Readmit Screener V2, dated December 27, 2024, at 6:27 PM revealed skin integrity documentation that assessed the resident as having moisture associated skin damage (MASD, damage to the skin caused by moisture), to the sacrum with measurements noted as one centimeter (cm) by 0.25 cm. Medical provider documentation for Resident CR1 dated January 2, 2025, at 5:57 PM revealed No new concerns voiced by nursing staff. The skin was documented as assessed as Warm and dry. No edema. There was no mention of the resident's skin tear on the sacrum as documented on admission by nursing staff. A skin and wound note from wound care (a third party wound management service that is contracted by the facility to perform various wound care needs/treatments/assessments) for Resident CR1 dated January 3, 2025, at 2:25 PM indicated Resident is seen today for a comprehensive skin assessment. Noted sacral Stage 3 pressure injury (Full-thickness loss of skin, in which subcutaneous fat may be visible) to the sacrum. The size was documented as one cm x 0.5 cm x 0.2 cm. The wound base was assessed as 100 percent granulation (pink-red moist tissue that fills an open wound, when it starts to heal). The wound status was documented as Present on admission. Treatment recommendations included: cleanse with wound cleanser, apply medical grade honey to base of the wound, secure with bordered foam, change every other day, and as needed. A review of the care plan for Resident CR1 noted the resident is at risk for skin integrity related to altered mobility and a Stage 3 pressure area to the sacrum. The care plan initiated date was March 7, 2025, which was after the resident was discharged from the facility. The associated interventions were also documented as created and initiated on March 7, 2025, after the resident was discharged from the facility. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review of the physician orders for Resident CR1 revealed an order for wound number one sacrum pressure treatment. Recommendations noted: cleanse with wound cleanser, apply medical grade honey to base of the wound, secure with bordered foam, change every other day, and as needed. The date of the order was January 6, 2025, with a start date of January 7, 2025, after the resident was discharged from the facility and four days after wound care assessed the resident's wound and made the initial recommendations. A review of the medication/treatment administration record (MAR/TAR, where staff document the administration of medications and treatments) for Resident CR1 for January 2025, revealed no evidence that the treatments were completed by the facility after being recommended by wound care on January 3, 2025. The facility could provide no further documentation or evidence that the recommendations were initiated in a timely manner as recommended by wound care, documented as completed, or staff were aware of these recommendations until after the resident was discharged from the facility. The above information for Resident CR1 was reviewed in a meeting with the Nursing Home Administrator on March 7 2025, at 1:35 PM. 28 Pa. Code 201.18(b)(1)(3) Management 28 Pa. Code 211.12(d)(1)(5) Nursing services

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 29512 Based on observation, clinical record review, and staff interview, it was determined that the facility failed to provide appropriate respiratory care and services for two of two residents reviewed (Residents 36 and 54). Findings include: According to the American Association for Respiratory Care proper cleansing of respiratory (nebulizer) equipment reduces infection risk. The longer a dirty nebulizer sits and is allowed to dry, the harder it is to clean thoroughly. Parts of the aerosol drug delivery device should be rinsed and then washed with soap and hot water after each treatment. Once completely dry, store the nebulizer cup and mouthpiece in a zip lock bag. Clinical record review for Resident 54 revealed a current physician's order for staff to provide oxygen at 2 liters per minute (LPM) via NC (nasal canula, tubing to deliver oxygen to the nose) continuously every shift, to change the oxygen tubing every Saturday night, label and date the new tubing for infection control, and make sure all tubing and nebulizer equipment (to help administer medication to the lungs) was bagged when not in use. Observation of Resident 54's room on March 4, 2025, at 11:47 AM, March 5, 2025, at 11:36 AM, and March 6, 2025, at 11:19 AM revealed that their oxygen concentrator was set at 2.5 LPM and that their nebulizer pipe was unbagged. The nebulizer tubing was dated February 23, 2025 (nine, 10, and 11 days prior to the observations). Concurrent interview with Resident 54 on March 6, 2025, revealed that staff was to change his tubing every week. Clinical record review for Resident 36 revealed current orders for staff to change the nebulizer tubing and bag every Saturday night shift. Staff are to label the tubing with the date, time, their initials, and make sure all tubing and nebulizer equipment was bagged when not in use. Observation of Resident 36's room on March 4, 2025, at 11:39 AM, March 5, 2025, at 8:29 AM, and March 6, 2025, at 8:25 AM and 11:17 AM revealed that their nebulizer pipe was unbagged\, and their tubing was dated February 23, 2025 (nine, 10, and 11 days prior to the observations). During each observation, there was an unopened bag dated February 23, 2025, lying on Resident 36's bedside stand and available for staff use. The above information was reviewed with the Nursing Home Administrator during an interview on March 6, 2025, at 9:16 AM. 28 Pa. Code 211.10 (c)(d) Resident care policies 28 Pa. Code 211.12(d)(1)(5) Nursing Services

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. 20725 Based on clinical record review and staff and resident interview, it was determined that the facility failed to provide behavioral health interventions for a resident to maintain the highest practicable mental well-being for one of two residents reviewed for behavioral concerns (Resident 44). Findings include: Clinical record review for Resident 44 revealed an admission MDS (Minimum Data Set, an assessment tool completed at specific intervals to determine resident care needs) dated December 13, 2024, that assessed that Resident 44 exhibited behavioral symptoms not directed towards others (e.g., physical symptoms such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily wastes, or verbal/vocal symptoms like screaming, disruptive sounds). Interview with Resident 44 on March 4, 2025, at 11:56 AM revealed that two staff provided her assistance to complete her most recent shower, and they were slam bam, with the shower care. Resident 44 denied that staff were abusive but confirmed that she did not appreciate the approach staff used when providing her care. Resident 44 recounted this incident several times during the interview despite attempts to redirect her to other topics. Review of electronic Task Documentation (electronic system for nurse aides to document the provision of care) dated February 2025, revealed that Employee 3 (nurse aide) documented Resident 44 received a shower on Friday evening, February 28, 2025. Interview with Employee 3 on March 5, 2025, at 2:25 PM, revealed that she remembered Resident 44's shower experience on February 28, 2025. Employee 3 stated that another nurse aide, Employee 6, asked her to witness Resident 44's shower care because Resident 44 was known to make false accusations against staff. Employee 3 stated that she witnessed Employee 6 begin to propel Resident 44 into the shower room via her wheelchair when Resident 44 began to get agitated stating that Employee 6 was hurting her shoulder (although Employee 6 had made no physical contact with Resident 44's body, only the handles of her wheelchair). Resident 44 began yelling at Employees 3 and 6 that they were going to damage her hearing aids in the shower although the hearing aids were in the charger in her room. Clinical record review for Resident 44 revealed a plan of care initiated December 7, 2024, that Resident 44 had a right to refuse care. Interventions included these instructions: If resident becomes agitated or combative remove your self (sic) from resident and reattempt when at a later time when calmer, and Staff will re-approach resident at a later time. A plan of care initiated by the facility on December 16, 2024, due to Resident 44's trigger for cognitive loss due to noted behaviors listed interventions that included, Provide the resident with necessary cues, stop, and reapproach if agitated. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility did not develop a care plan for Resident 44 that included an intervention that two staff should provide care due to her known behavior of false accusations. Staff failed to implement the interventions to stop care and reapproach Resident 44 when she exhibited agitated behaviors with false accusations. The surveyor reviewed the above concerns regarding Resident 44 during an interview with the Nursing Home Administrator and Employee 5 (director of rehab) on March 5, 2025, at 2:00 PM. 28 Pa. Code 211.12(d)(1)(5) Nursing services

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 20725 Based on observation and staff interview, it was determined that the facility failed to securely store medications on one of two nursing units (Unit One dining room); and failed to ensure medication labeling for one of seven residents observed for medication administration (Resident 46). Findings include: Observation of a medication administration pass on March 5, 2025, at 9:01 AM revealed Employee 2 (licensed practical nurse, LPN) prepared medications for administration to Resident 46. Employee 2 crushed Resident 2's Rosuvastatin (medication used to lower cholesterol) 10 mg (milligram) tablet and administered the medication to Resident 46. The medication resource Drugs.com stipulated that a consumer should swallow a Rosuvastatin tablet whole. Interview with Employee 2 on March 5, 2025, at 9:10 AM confirmed that she crushed Resident 46's Rosuvastatin medication. Employee 2 verified that there were no instructions on the medication labeling from the pharmacy that stipulated one should not crush the medication, and she was not aware of the precaution. Interview with Employee 1 (registered nurse) on March 5, 2025, at 9:12 AM indicated that the medication resource, Medline Plus, used by the facility's nursing staff, also stipulated that the medication Rosuvastatin should not be crushed. The facility failed to ensure that all medication labeling included appropriate precautionary instructions. Observation of the main dining area on Unit One on March 4, 2025, at 2:27 PM revealed a yellow-colored, round pill located on the floor behind a small television stand that was located underneath the wall-mounted television. An interview with Employee 2, LPN, on March 4, 2025, at 2:30 PM revealed the LPN was unable to identify the pill. The LPN proceeded to dispose of the medication. The above information for the pill found on the floor in the main dining area of Unit One was reviewed in a meeting with the Nursing Home Administrator on March 7, 2025, at 11:50 AM. 28 Pa. Code 211.9(f)(2)(k) Pharmacy services 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20725 Based on clinical record review, observation, and resident and staff interview, it was determined that the facility failed to obtain dental services for one of four residents reviewed for dental concerns (Resident 52). Findings include: Interview with Resident 52 on March 5, 2025, at 9:29 AM revealed that she utilized a partial dental plate to fill in the gap in her top teeth; however, that partial no longer fit. Resident 52 indicated that there were discussions regarding the replacement of the partial (between her son, the facility, and a dental provider), but she did not know if or when she would receive a new one. Observation of Resident 52 during the interview revealed that she had several missing front teeth. Clinical record review for Resident 52 revealed that Medicaid was a payer for her care as of August 23, 2024. Nursing documentation dated November 15, 2024, at 10:14 PM revealed that Resident 52 complained of left-sided dental pain. Staff assessed that the left side of Resident 52's face had visible swelling. Nursing documentation dated November 22, 2024, at 11:49 PM revealed that staff administered the antibiotic, Augmentin, for a dental infection. Resident 52's medical record contained no evidence that a professional dental provider evaluated Resident 52's diagnosed dental infection. Progress note documentation by the facility's contracted dental provider dated February 6, 2025, identified Resident 52 had cracked and missing teeth, a mesial drift (the natural inclination of teeth to shift toward the front of the mouth), and had a partial upper denture. The documentation confirmed that Resident 52 wanted a new partial denture; however, she had two teeth that were not restorable and had a root tip retained from a third tooth. Those teeth would need extracted prior to fabricating a new upper partial denture. Interview with the Nursing Home Administrator on March 7, 2025, at 9:22 AM confirmed that Resident 52 was admitted to the facility on [DATE]; however, the facility did not offer or obtain consent for professional dental services until July 10, 2024. The interview indicated that the facility had no evidence that Resident 52 received professional dental services for the almost year from March 13, 2024, to February 6, 2025, (despite Resident 52 had a dental infection that required antibiotics in November 2024). 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 29512 Based on observation and staff interview, it was determined that the facility failed to store, prepare, and serve food in a manner to prevent the potential spread of foodborne illness in the main kitchen and the facility's pantry for one of two nursing units (Unit 1 Nursing Unit). Findings include: According to HACCP (Hazard Analysis and Critical Control Points) to avoid the potential for food borne illness, food must be cooled from 135 degrees Fahrenheit to 70 degrees Fahrenheit within two hours, and from 70 degrees Fahrenheit to 41 degrees Fahrenheit or lower in the next four hours. Before cooling food, reduce the quantity or size of the food you are cooling by dividing large food items into smaller portions. Observation and review of the facility's cool down logs with Employee 4, certified dietary manager, on March 4, 2025, at 10:39 AM revealed that facility staff documented the following on February 28, 2025: At 9:45 AM staff cooked four beef rounds and initiated cooling them down for food service at a later date. The beef rounds temperatures were documented as 178 degrees Fahrenheit, 202 degrees Fahrenheit, 199 degrees Fahrenheit, and 172 degrees Fahrenheit respectively. At 10:30 AM (45 minutes later) staff completed four beef round temperatures that were documented as 146 degrees Fahrenheit, 140 degrees Fahrenheit, 137 degrees Fahrenheit, and 147 degrees Fahrenheit respectively. At 11:30 AM (1 hour and 45 minutes later) staff completed four beef round temperatures that were documented as 100 degrees Fahrenheit, 85 degrees Fahrenheit, 76 degrees Fahrenheit, and 89 degrees Fahrenheit respectively. At 12:30 AM (2 hours and 45 minutes later) staff completed four beef round temperatures that were documented as 69 degrees Fahrenheit, 61 degrees Fahrenheit, 66 degrees Fahrenheit, and 64 degrees Fahrenheit respectively. There was no other documentation that indicated staff completed any further cool down temperatures on the four beef rounds. There was no documentation that the four beef rounds reached 40 degrees Fahrenheit, a safe food holding temperature, within a total of four hours after reaching 70 degrees Fahrenheit and within a total of six hours after the potentially hazardous food cool down was initiated. Review of the facility's food service temperature logs dated March 2, 2025, revealed that the facility served the above noted beef rounds as roast beef to residents. Concurrent interview with Employee 4 acknowledged the beef round cool down temperature documentation and subsequent usage. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observation of the Unit 1 Nursing pantry on March 5, 2025, at 9:35 AM revealed that the microwave had dried, stuck-on food on the walls and ceiling. In a lower cabinet to the left of the refrigerator, there were 12 cartons of vanilla Glucerna (a food supplement) with a use by date of February 1, 2025, that were available for resident use. Interview and observation of the Unit 1 Nursing pantry with Employee 4 on March 5, 2025, at 9:41 AM confirmed the above information. The above concerns were reviewed with the Nursing Home Administrator during an interview on March 5, 2025, at 2:15 PM. 483.60(i)(1)(2) Food Procurement. store/prepare/serve Sanitary Previously cited 4/19/24 28 Pa. Code 201.14 (a) Responsibility of licensee.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 44738 Based on observation, clinical record review, and resident and staff interview, it was determined that the facility failed to implement appropriate enhanced barrier transmission-based precautions for one of 18 residents reviewed (Resident 75) Findings include: Review of the memo entitled Enhanced Barrier Precautions (EBP, gown and glove use) in Nursing Homes to Prevent the Spread of Multi-drug Resistant Organisms released by the Center for Medicaid and Medicare Services (CMS) on March 20, 2024, with an implementation date of April 1, 2024, revealed that nursing care facilities are to use EBP for residents with chronic wounds or indwelling medical devices during high-contact resident care activities regardless of their multidrug-resistant organism status. High-contact activity would include things like dressing, transferring, changing linens, providing hygiene, changing briefs, wound care, or device care. Review of the facility policy titled, Infection Prevention Control 2024 Plan, last reviewed without changes on June 13, 2024, revealed that EBP are an infection control intervention designed to reduce transmission of multi-drug resistant organisms (MDRO, bacteria that resist treatment to antibiotics) through gown and glove use by healthcare professionals in long-term care settings in accordance with the Centers for Disease Control and Prevention (CDC) consideration for use of EBP in skilled nursing facilities. EBP are recommended during high contact care (dressing, bathing, transferring, changing brief or assisting with toileting, device care, wound care, etc.) activities with residents who are at higher risk of acquiring or spreading and MDRO (residents with indwelling medical devices or wounds). EBP should be followed (when contact precautions do not otherwise apply) for residents with any of the following: open wounds requiring a dressing change, indwelling medical devices (central line, urinary catheter, feeding tubes, etc., tracheostomy/ventilator) regardless of MDRO status. Clinical record review for Resident 75 revealed a current physician's order dated February 19, 2025, for hemodialysis (treatment for kidney failure; an external medical device that filters extra fluid and waste products from the blood) on Monday, Wednesday, and Friday at 11:00 AM. Nursing documentation for Resident 75 dated February 17, 2025, at 9:57 PM revealed the resident was admitted and had a tunneled dialysis catheter to the right chest. Hospital documentation dated February 5 to 17, 2025, revealed the resident had a tunneled dialysis catheter placed to the right chest wall. Further review of the clinical record revealed no evidence to indicate that Resident 75 was on any type of enhanced barrier precautions. Observation of Resident 75 on March 7, 2025, at 11:15 AM revealed no evidence that the resident was on EBP (no sign indicating EBP precautions, no personal protective equipment (PPE) in the room or at the doorway to don, or any sign placed that instructed to see the nurse prior to care). A concurrent interview with the resident with Employee 1, registered nurse, at the bedside, confirmed that the resident does have a tunneled dialysis catheter in the right upper chest. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with the Nursing Home Administrator on March 7, 2025, at 12:23 PM revealed that the resident was not on EBP; however, is supposed to be on them per the facility policy. 483.80(a)(1)(2)(4)(e)(f) Infection Prevention and Control Previously cited deficiency 4/19/24 28 Pa. Code 201.18(b)(1) Management 28 Pa. Code 211.10(d) Resident care policies 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services

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F 0922 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have enough backup water supply for essential areas of the nursing home. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44738 Based on review of select facility policy and procedures, observation, and staff interview, it was determined that the facility failed to follow established procedures of water storage to ensure that water is available to essential areas when there is a loss of normal water supply for two of two nursing units (Unit 1 and Unit 2). Findings include: A review of the facility policy titled, Water Availability, last reviewed without changes on [DATE], revealed that the facility will ensure water availability to essential areas when there is a loss of normal water supply. Further review of the policy revealed that, This water will be rotated on a regular basis. Observation of a storage area on Nursing Unit 1 across from the main dining area on [DATE], at 9:56 AM revealed a large shelving unit that held multiple cardboard boxes. Each cardboard box contained six gallons of water. A concurrent interview with Employee 8, medical records and human resources, revealed the boxes containing the gallons of water were the facility's emergency water supply. Further observation of the boxes of water revealed six of the nine boxes reviewed were past the manufacturer's best by dates. Two boxes had a best by date of [DATE], and four of the boxes had a best buy date of [DATE]. The associated dates were also stamped near the top of each gallon of water. An interview with the Nursing Home Administrator on [DATE], at 10:04 AM revealed it was unclear why the expired boxes of water had not been disposed of. An interview with Employee 4, certified dietary manager, on [DATE], at 10:06 AM revealed that additional boxes of water for the emergency supply were also kept in storage in the facility's main kitchen area. Observation of these additional boxes of water with Employee 4 on [DATE], at 10:10 AM revealed multiple boxes of water stored in the dry goods storage section of the facility's main kitchen. Four of the 10 boxes of water reviewed revealed that the boxes were past the expiration dates: three boxes of water were dated with a best by date of [DATE]; and one box of water had a past best by date of [DATE]. There was no further evidence provided by the facility to ensure that the emergency water supply was rotated on a regular basis, as indicated in the facility's policy and procedure, to ensure water that was past the best by date was removed from the supply. 28 Pa. Code 201.18(b)(1) Management