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	04/03/2026

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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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. Based on a review of select facility policies and procedures, observation, clinical record review, and staff interview, it was determined that the facility failed to assess potential entrapment risks from the use of side rails for four of four residents reviewed for accident hazards (Residents 5, 42, 6, and 70). Findings include: The FDA (The United States Food and Drug Administration) Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment, is guidance that identifies key parts of the body at risk for entrapment, describes potential entrapment areas or zones, and recommends maximum and minimum dimensional limits of gaps or openings in hospital bed systems. Three key body parts at risk for life-threatening entrapment in the seven zones of a hospital bed system discussed in this guidance are the head, neck, and chest. To reduce the risk of head entrapment, openings in the bed system should not allow the widest part of a small head (head breadth measured across the face from ear to ear) to be trapped. The FDA is using a head breadth dimension of 120 mm (4.75 inches) as the basis for its dimensional limit recommendations. To reduce the risk of neck entrapment, openings in the bed system should not allow a small neck to become trapped. FDA is recommending 60 mm (two and three-eighths inches) as an appropriate dimension for neck diameter. The openings in a bed system should be wide enough not to trap a large chest through the opening between split rails. The FDA concurs with the dimension of 318 mm (12.5 inches) to represent chest depth for the population vulnerable to entrapment and has used this dimension as the basis for its recommended dimensional limits. This guidance describes seven zones in the hospital bed system where there is potential for patient entrapment. Zone six is the space between the end of the rail and the side edge of the headboard or footboard. This space may present a risk of either neck entrapment or chest entrapment. The facility policy entitled, Side Rail Policy and Procedure, last reviewed without changes on June 3, 2025, revealed that when side rail usage is deemed appropriate, the facility will assess the space between the mattress and side rails to reduce the risk for entrapment; however, the facility did not identify that the space between the side rails and a headboard or footboard may also present a risk for entrapment. Observation of Resident 5 on March 31, 2026, at 1:54 PM revealed him to be in his bed which was equipped with siderails bilaterally at the head of his bed, a headboard, and a footboard. Clinical record review for Resident 5 revealed a Side Rail Entrapment Assessment (document used by the facility to indicate an assessment of the seven zones of potential entrapment risks) dated January 2, 2026, that Employee 1 (physical therapist) documented zone six was, N/A (not applicable), for Resident 5. The document questioned if an angle at the end of the rail and side of the headboard was greater than 60 degrees. The document did not question if the gap between the end of the rail and the side edge of the headboard/footboard presented a risk of entrapment (e.g., a size that could trap a head, neck, or chest). The surveyor reviewed the above concern regarding Resident 5's side rail entrapment assessment during an interview with the Nursing Home Administrator and the Director of Nursing on April 2, 2026, at 2:40 PM. Observation of Resident 5's bed system with Employee 1 and the Nursing Home Administrator on April 2, 2026, at 3:00 PM confirmed that Resident 5's bed was equipped with a side rail on each side (continued on next page)

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

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	of his bed, a headboard, and a footboard. Employee 1 measured the gap between the end of the side rail and the headboard to be approximately two inches. The surveyor reviewed with Employee 1 and the Nursing Home Administrator that given Resident 5's bed system created a gap between the end of the rail and the headboard, the assessment of zone 6 should have determined that no entrapment risks existed, not that the assessment was not applicable. Observation of Resident 42's bed system on March 31, 2026, at 2:22 PM revealed that her bed was equipped with side rails bilaterally at the head of her bed, a footboard, and a headboard. Clinical record review for Resident 42 revealed a Side Rail Entrapment Assessment completed by Employee 1 on February 2, 2026, that assessed zone 6 as not applicable. The surveyor reviewed Resident 42's bed system created a gap between the end of the rail and the headboard, the assessment of zone six as not applicable would be an error, and that the facility should have determined that no entrapment risks existed in that zone during an interview with the Director of Nursing and the Nursing Home Administrator on April 2, 2026, at 2:00 PM. Observation of Resident 6 on March 31, 2026, at 12:21 PM revealed them to be in their bed which was equipped with siderails bilaterally at the head of their bed, and a headboard. Clinical record review for Resident 6 revealed a Side Rail Entrapment Assessment completed by Employee 1 on March 13, 2026, that assessed zone 6 as not applicable. Observation of Resident 70 on March 31, 2026, at 12:39 PM revealed them to be in their bed which was equipped with a grab bar to the resident's left side while they are in bed, and a headboard. Clinical record review for Resident 70 revealed a Side Rail Entrapment Assessment completed by Employee 1 on March 12, 2026, that assessed zone 6 as not applicable. During an interview with the Nursing Home Administrator and the Director of Nursing on April 2, 2026, at 2:00 PM, the surveyor reviewed that Resident 6's and Resident 70's bed system created a gap between the end of each rail and the headboard, and that the assessment of zone 6 should have determined that no entrapment risks existed, not that the assessment was not applicable. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. Based on clinical record review, observation, and resident and staff interview, it was determined that the facility failed to ensure a medication error rate less than five percent (Residents 10 and 59).Findings include:The facility's medication error rate was 7.41 percent based on 27 medication opportunities with two medication errors.Observation of a medication administration pass on April 1, 2026, at 8:09 AM revealed Employee 4 (licensed practical nurse) administer Sucralfate (anti-ulcer medication, adheres to the stomach lining to protect it from acids and enzymes) 1 gm (gram) to Resident 59. The packaging of the Sucralfate medication included instructions to administer the medication on an empty stomach. Resident 59 had their breakfast tray in front of them on their bedside table and had already eaten half of a pancake when their medications were administered. The medication reference Drugs.com (a comprehensive and widely visited website that provides free, peer-reviewed, accurate, and independent drug information) instructions regarding the administration of sucralfate note, Take sucralfate on an empty stomach.Continued observation of a medication administration pass on April 1, 2026, at 8:27 AM revealed Employee 4 administered Bethanechol Tablet 25 MG (milligram) (a medication used to treat bladder spasms and urinary retention). The packaging of the bethanechol medication included instructions to administer the medication on an empty stomach. Resident 10 had their breakfast tray in front of them on their bedside table and had eaten all their breakfast when their medications were administered.The medication reference Drugs.com instructions regarding the administration of bethanechol note, Take bethanechol on an empty stomach, at least 1 hour before or 2 hours after a meal.Interview with Employee 4 on April 1, 2026, at 8:36 AM indicated that she was not aware of the special instruction packaging instructions listed for the medications for Resident 59 and Resident 10.The surveyor reviewed the above two medication error concerns during an interview with the Nursing Home Administrator and the Director of Nursing on April 1, 2026, at 12:30 PM. 28 Pa. Code 211.12(d)(1)(5) Nursing services

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation and staff interview, it was determined that the facility failed to store food and maintain food service equipment and envrionment in accordance with professional standards for food service safety in the facility's main kitchen. Findings include: Observation of the facility's main kitchen on March 31, 2026, at 10:05 AM revealed the following: A small silver metal open rack shelving unit storing clean bowls, cups and other assorted dishes located next to the tray line that had a buildup of dust between the metal wires. The two-door oven had a buildup of brown stains on the bottom of the oven and on the glass of the oven doors. A large amount of food debris was observed on the floor under the oven and stove with black buildup also noted on the tile grout in the corner by the oven. A large metal open wire rack storage shelving unit was observed with clean dishes stored on it. The lowest shelf was observed 10 inches from the floor with no solid barrier between the shelf and the floor to prevent the potential contamination of the dishes from mop water splash or sweeping of the floor debris. The dishwasher room floor under the equipment appeared wet and was dark brown in color. A white pipe that ran under the unit was coated in a brown substance where it ran along the floor under the dishwasher. Two coffee mugs were noted to be in the corner under the dishwashing machine. The floors in the adjoining walk-in freezer and refrigerator had food debris under the shelving units. A dark brown liquid was noted at the threshold of the freezer doors, measuring eight inches long and spreading into the adjoining walk-in refrigerator. The corners of the flooring in the walk-in refrigerator had black buildup in the tile grout. The floor under the ice machine had a white build up, and a cup was noted underneath. The edges of the floor around the wall next to the ice machine were noted with a large amount of brown build up in the grout of the tile floors. The above information was reviewed in a meeting with the Nursing Home Administrator and Director of Nursing on April 1, 2026, at 2:30 PM. 483.60(i)(2) Store food safe and sanitaryPreviously cited 3/7/25 28 Pa. Code 201.14(a) Responsibility of licensee

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and staff and resident interview, it was determined that the facility failed to ensure assessments accurately reflected residents' status for three of 24 residents reviewed (Residents 5, 30, and 55).Findings include: Clinical record review for Resident 55 revealed a quarterly MDS (Minimum Data Set, an assessment tool completed at specific intervals to determine resident care needs) dated January 9, 2026, in which facility staff assessed the resident as taking an antibiotic. Further clinical record review revealed no evidence that Resident 55 was on an antibiotic at that time. An interview with Employee 2, registered nurse, on April 3, 2026, at 1:01 PM confirmed that Resident 55 was not on an antibiotic during the assessment period and this was marked in error on the MDS. The Nursing Home Administrator was informed of the above findings for Resident 55 during a meeting on April 3, 2026, at 1:17 PM. Interview with Resident 30 on April 1, 2026, at 10:12 AM revealed that he was waiting for an outside provider to evaluate him and provide him with prosthetics for his legs as he was a bilateral leg amputee (right above the knee, left below the knee). Review of Resident 30's diagnoses list substantiated that his left leg was amputated below the knee joint and his right leg was amputated above the knee joint. His diagnoses also included that he had abnormalities of gait and mobility and reduced mobility since January 3, 2024. An annual MDS dated [DATE], indicated that Resident 30 had no range of motion impairments of either his upper or lower extremities. A quarterly MDS dated [DATE], indicated that Resident 30 had lower extremity range of motion impairment on only one side. The Minimum Data Set (MDS) 3.0 Resident Assessment Instrument (RAI) Manual (guidance how to complete and use the MDS assessments) instructions to complete the range of motion section of the MDS assessment noted that if a resident with an amputation does indeed have difficulty completing ADLs (activities of daily living) and is at risk for injury, the facility should code this item as appropriate. This item is coded in terms of function and risk of injury, not by diagnosis or lack of a limb or digit. The annual MDS dated [DATE], and the quarterly MDS dated [DATE], assessed that Resident 30 required substantial/maximal assistance for toileting and standing from sitting position and chair-to-bed-to-chair transfers and partial/moderate assistance for rolling left and right in bed and sitting to lying in bed. Ambulation was not assessed on either assessment and noted as, not applicable. A plan of care initiated by the facility on January 3, 2024, to address Resident 30's risk for falls noted that Resident 30 was a bilateral amputee. The plan of care errantly included that Resident 30 should have appropriate footwear when ambulating or mobilizing in his wheelchair. The plan of care also included that Resident 30 should have non-skid socks on when he was in bed. Interview with the Director of Nursing and the Nursing Home Administrator on April 2, 2026, at 2:12 PM confirmed that the MDS coding related to Resident 30's range of motion failed to capture his range of motion impairments that affected his activities of daily living and safety. Clinical record review for Resident 5 revealed a quarterly MDS dated [DATE], that assessed him as having a wound infection. Review of, Skin and Wound Note, progress notes dated January 8, 2026, and nursing documentation dated January 9, 2026, at 5:29 AM, revealed that Resident 5 had skin impairments, however, neither entry indicated that he had a wound infection. Nursing documentation dated January 14, 2026, at 6:43 AM indicated that Resident 5 required an antibiotic for a urinary tract infection. The surveyor did not identify evidence to support that Resident 5 had a wound infection at the time of the completion of the January 13, 2026, MDS assessment. Interview with the Nursing Home Administrator on April 3, 2026, at 11:45 AM confirmed that the facility determined that Resident 5's coding on the MDS assessment for a wound infection was an error. 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. Based on clinical record review, review of facility documentation, and staff interview, it was determined that the facility failed to provide the highest practical care regarding a physician ordered fluid restriction for one of 18 residents reviewed (Resident 43).Findings include: A review of the diagnosis list for Resident 43 revealed a medical history that included the following: acute kidney failure and chronic combined systolic and diastolic heart failure (a chronic condition where the heart is unable to meet the needs of body and can lead to symptoms such as fluid buildup in the lungs and legs). A review of the current physician orders for Resident 43 revealed an order dated August 24, 2025, for a 1200 cc (cubic centimeter) fluid restriction; 120 with AM (morning) med pass and 120 cc with HS (bedtime) med pass. A review of the current care plan for Resident 43 revealed the resident has an altered cardiovascular status and chest pain related to the medical history, is at an increased nutritional risk, and has a 1200 ml (milliliter) fluid restriction. An intervention also included the 1200 ml fluid restriction (fluid restrictions included breakfast 300 ml, lunch 300 ml, dinner 300 ml, and nursing total for all medication passes 300 ml). A review of fluid intake for the past 30 days on Resident 43's task list (located in the electronic health record where staff document specific care related events for a resident) revealed the following days where staff had documented the resident's fluid intake which exceeded the 1200 ml fluid restriction: March 6, 2026: 1460 mlMarch 7, 2026: 1600 mlMarch 8, 2026: 1780 mlMarch 9, 2026: 1260 mlMarch 10, 2026: 1650 mlMarch 13, 2026: 1700 mlMarch 14, 2026: 2520 mlMarch 19, 2026: 1500 mlMarch 20, 2026: 1320 mlMarch 22, 2026: 1420 mlMarch 23, 2026: 2380 mlMarch 24, 2026: 1320 mlMarch 28, 2026: 1560 mlMarch 29, 2026: 1760 mlMarch 30, 2026: 1250 mlApril 1, 2026: 1240 mlApril 2, 2026: 1540 ml There was no documentation for Resident 43 that indicated the resident refused to adhere to the ordered and care planned fluid restriction. There was no documentation that indicated the physician was made aware that the resident had exceeded the ordered 1200 ml fluid restriction on the above dates. The Nursing Home Administrator confirmed during a meeting on April 3, 2026, at 1:19 PM that there was no further documentation found for Resident 43 that the resident had refused to adhere to the ordered and care planned fluid restriction or the resident's physician was made aware that the ordered fluid restriction was exceeded. 483.25 Quality of CarePreviously Cited 3/7/25 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on clinical record review and staff interview it was determined that the facility failed to implement interventions to prevent a resident fall for one of seven residents reviewed for falls (Resident 2).Findings include: Clinical record review for Resident 2 revealed a Fall Report (assessment performed that identified the resident's fall risk level based on score: one to four, low fall risk; five to nine, moderate fall risk; and 10 or greater, high fall risk) dated December 2, 2025, that assessed her score as 14 (high risk). Review of a plan of care initiated by the facility (November 5, 2024) to address Resident 2's fall risk revealed interventions that included: Chair alarm (initiated November 11, 2025)Encourage resident to use handrails or assistive devices properly (initiated November 5, 2024) Review of an annual MDS (Minimum Data Set, an assessment tool completed at specific intervals to determine resident care needs) dated November 14, 2025, revealed that staff assessed Resident 2 as requiring the supervision or touching assistance of staff to sit from a lying position, stand from a seated position, transfer to and from a bed to a chair, and to walk 10 to 150 feet. The assessment did not indicate that Resident 2 utilized a wheelchair. The assessment indicated that Resident 2 utilized a walker. Nursing documentation dated December 20, 2025, at 2:50 PM revealed that the registered nurse heard Resident 2 yelling, help me, I fell. Staff observed Resident 2 lying on her left side in front of her wheelchair in front of a resident room on the 700 hallway (Resident 2 resided on the 600 hallway). The documentation indicated that staff, Assisted from the floor into wheelchair with two assist. Review of the facility's investigation of the incident dated December 20, 2025, revealed that staff identified Resident 2, was in a different wheelchair without alarm. Interventions implemented to attempt to prevent future falls for Resident 2 included to educate staff regarding the importance of ensuring the resident is in the assigned wheelchair. Review of Resident 2's care plans revealed that the facility revised her fall risk care plan on December 20, 2025, to include the intervention for staff to ensure Resident 2 was always seated in her assigned wheelchair to promote proper fit and stability and ensure chair alarm is in place and activated. The facility failed to implement all fall prevention interventions for Resident 2 on December 20, 2025, that contributed to her fall. The surveyor reviewed the above concerns regarding Resident 2's fall on December 20, 2025, with the Nursing Home Administrator and the Director of Nursing on April 3, 2026, at 10:45 AM. 28 Pa. Code 211.10(d) Resident care plan 28 Pa. Code 211.12(d)(1)(5) Nursing services

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Sayre Health Care Center	151 Keefer Lane Sayre, PA 18840

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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. Based on clinical record review, observation, and staff and resident interview, it was determined that the facility failed to provide respiratory care for a BiPAP (bilevel positive airway pressure)/CPAP (continuous positive airway pressure) device consistent with professional standards of practice one of one resident reviewed for respiratory concerns (Resident 29).Findings include: Clinical record review for Resident 29 revealed a diagnosis list that included obstructive sleep apnea (periods of breathing cessation during sleep). Review of Resident 29's care plan revealed the resident uses oxygen therapy and has an altered respiratory status related to the medical history. The interventions included: BiPAP cleaning per facility policy and BiPAP on at bedtime with settings as ordered. A review of the current physician orders for Resident 29 revealed no order for BiPAP, CPAP, or related. Medical provider documentation for Resident 29 dated December 29, 2025, at 8:22 AM revealed a history of obstructive sleep apnea. The documentation noted, Staff to assist with BiPAP at bedtime. Observation of Resident 29's room on April 1, 2026, at 11:48 AM revealed a BiPAP/CPAP device on the resident's dresser next to the bed. It was not in use. A follow-up observation and concurrent interview for Resident 29 on April 3, 2026, at 10:30 AM revealed that the resident was in bed. The BiPAP/CPAP device remained on the dresser and was not in use. The resident stated she used the device at home but was unable to state if she used it in the facility. An interview with Employee 3, licensed practical nurse, on April 3, 2026, at 10:34 AM revealed that the resident utilizes the device overnight. An interview and concurrent observation of Resident 29's room on April 3, 2026, at 10:45 AM confirmed the device was used for BiPAP and/or CPAP and had an attached mask that was in a plastic bag and distilled water next to the device. The Director of Nursing would have to review the resident's chart to confirm further if the resident was to use the device or not. A follow-up interview with the Director of Nursing on April 3, 2026, at 1:37 PM revealed that the resident does not use the device and it was not removed from the care plan. The facility provided no further documentation on the device. 483.25(i) Respiratory/tracheostomy Care and SuctioningPreviously cited deficiency 3/7/25 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. Based on clinical record review and resident and staff interview, it was determined that the facility failed to develop a trauma-informed plan of care for one of one resident reviewed for behavioral-emotional concerns (Resident 11).Findings include: Clinical record review for Resident 11 revealed a quarterly MDS (Minimum Data Set, an assessment tool completed at specific intervals to determine resident care needs) dated September 4, 2025, that identified Resident 11 had a Post Traumatic Stress Disorder (PTSD, intrusive thoughts related to a traumatic event, can manifest as flashbacks where the person feels as though they are reliving the trauma). Review of Resident 11's diagnoses list revealed that the facility included Resident 11's PTSD diagnosis since November 25, 2024. Interview with Resident 11 on April 2, 2026, at 1:15 PM revealed that trauma experienced in her past included that she was, raped by five men when (she) was a girl, and her father, .was a drunk and beat (her), and she, .married young in Alabama and (her husband) beat , her. The traumatic events described by Resident 11 all related to male relationships and treatment by males. Resident 11 stated that she performed all her personal hygiene, bathing, and toileting needs independently; and could not accept care assistance in those areas by a male caregiver. Review of a plan of care initiated November 28, 2024, to address that Resident 11, was admitted for a dx (diagnosis) of PTSD, revealed that the facility noted that her PTSD was caused from recent events and did not include any reference to the traumatic events reported to the surveyor by Resident 11. Interventions included in the plan of care did not include the use of outside psychological resources, the restriction of male caregivers for personal care, or the use of medications to treat the symptoms of her PTSD diagnosis. Progress note documentation from the facility's consulting psychological provider dated November 25, 2025, noted that Resident 11's use of Sertraline (antidepressant medication) and Clonazepam (antianxiety medication) were for her PTSD diagnosis, however, the documentation did not note the traumatic events that supported the PTSD diagnosis, potential triggers that could cause Resident 11 to relive the trauma, or non-medicinal interventions necessary to prevent those triggers. Progress note documentation by the facility's consulting psychological provider dated January 8, 2026, March 12, 2026, and March 26, 2026, no longer included Resident 11's PTSD diagnosis, however, continued to include the Sertraline and Clonazepam medications in her medication list. The surveyor reviewed concerns that Resident 11's plan of care and outside psychological treatment did not address her reported trauma and care preferences during an interview with the Director of Nursing and the Nursing Home Administrator on April 2, 2026, at 2:00 PM. The facility failed to account for Resident 11's experiences and preferences to eliminate or mitigate triggers that may cause re-traumatization for her. 28 Pa. Code 211.10(d) Resident care plan 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on clinical record review, review of facility documentation, and staff interview, it was determined that the facility failed to ensure the accurate acquiring and administration of medications to meet the needs of one of 18 residents reviewed (Resident 29).Findings include: Review of physician orders for Resident 29 revealed an order dated December 26, 2025, for Potassium Chloride extended release (ER) 20 milliequivalents (MEQ); give one tablet by mouth two times a day for low potassium. A review of the Medication Administration Record (MAR) for Resident 29 revealed that the resident's potassium was not documented as administered per the physician order and the associated MAR notes revealed that staff had documented the following: January 3, 2026, at 9:58 AM: on orderJanuary 5, 2026, at 9:16 AM: awaiting pharmacyJanuary 7, 2026, at 7:29 PM: awaiting pharmacyJanuary 12, 2026, at 9:29 AM: awaiting pharmacyJanuary 13, 2026, at 10:05 AM: Awaiting pharmacy. Unable to pull from pharmacy.January 13, 2026, at 7:13 PM: awaiting pharmacyJanuary 15, 2026, at 9:39 AM: Awaiting pharmacy. Not available in cubex. January 16, 2026, at 11:21 AM: awaiting pharmacyJanuary 19, 2026, at 9:09 AM: not in pack, not available in cubexJanuary 20, 2026, at 10:06 AM: awaiting pharmacy, not available in cubex Facility documentation for Resident 29 titled, Provider Notification Form, dated January 14, 2026, revealed a nurse issue that on January 12-13, 2026, the resident had missed doses of potassium chloride tablets while awaiting pharmacy arrival. The physician response noted that it was ok to administer when received from pharmacy. Another Provider Notification Form for Resident 29 dated January 17, 2026, revealed that on January 15-16, 2026, potassium chloride 20 MEQ was not available in the cubex and awaiting refill and the doses were missed. The physician response noted that it was ok to administer when received from pharmacy. Another Provider Notification Form for Resident 29 dated January 20, 2026, revealed that potassium chloride oral packet 20 MEQ was unavailable in the cubex and awaiting refill / pharmacy. It documentation noted missed doses on January 18-19. The physician response noted that it was ok to administer when received from pharmacy. An interview with Employee 2, registered nurse, on April 2, 2026, at 2:22 PM revealed that facility staff had pulled out the available potassium chloride from the cubex and pharmacy was notified of this. The facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of Resident 29. The above information was reviewed in a meeting with the Nursing Home Administrator and Director of Nursing on April 1, 2026, at 2:00 PM. 28 Pa. Code 211.9 (k) Pharmacy services 28 Pa. Code 211.12(c)(d)(1)(3)(5) Nursing services

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	395101	A. Building B. Wing	04/03/2026

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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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. Based on review of select facility policies and procedures, clinical record review, and staff interview, it was determined that the facility failed to ensure the consultant pharmacist reported potential medication irregularities to the attending physician and that the physician provided an appropriate timely response for one of five residents reviewed for medication regimen review (Resident 5).Findings include: The facility policy entitled, Medication Regimen Review, last reviewed without changes on June 3, 2025, revealed that the medication regimen of each resident is reviewed by a licensed pharmacist according to federal, state, and local regulations as well as current standards of practice. The pharmacist must report any irregularities to the attending physician, the facility's medical director, and the Director of Nursing, and these reports must be acted upon in a manner that meets the needs of the residents. If no irregularities are identified, the consultant pharmacist will document, No Irregularities, in the designated location within the Electronic Health Record (EHR). A written report of all irregularities and recommendations resulting from the medication regimen review are provided to a facility designee for the attending physician, Director of Nursing, and medical director. The report will be submitted within 72 hours of the actual review. For non-urgent recommendations, the facility and attending physician must address the recommendation(s) in a timely manner that meets the needs of the resident, but no later than their next routine visit to assess the resident. Clinical record review for Resident 5 revealed a progress note from the facility's contracted pharmacist dated May 15, 2025, at 8:23 AM that the MRR (medication regimen review) was complete and to see a, nursing/physician report for any irregularities and/or action items. The documentation did not stipulate if the potential irregularity was reported to the nurse, or the physician, or to both. Interview with the Nursing Home Administrator and the Director of Nursing on April 3, 2026, at 10:45 AM revealed that the facility had no consultant reports to provide for Resident 5's May 15, 2025, recommendation to the physician. A report provided by the Director of Nursing on April 3, 2026, at 12:59 PM revealed that the consultant pharmacist identified a potential medication irregularity on May 15, 2025, that Resident 5 had multiple orders for the same PRN (as needed) indication; the same dose, frequency, and PRN indicator for Tylenol (Acetaminophen, over-the-counter analgesic) Extra Strength. The recommendation questioned whether one of the orders could be discontinued. A progress note dated May 26, 2025, indicated that Resident 5's physician made a routine visit. A progress note dated June 11, 2025, indicated that Resident 5's physician assessed Resident 5 in response to a fall. A progress note dated June 19, 2025, indicated that Resident 5's physician made a routine visit. The physician did not respond to the consultant pharmacist's identified medication irregularity of May 15, 2025, until July 3, 2025. The physician discontinued one of the PRN Tylenol orders for Resident 5. Progress note documentation by the consultant pharmacist dated June 17, 2025, at 9:56 AM indicated that the MRR was complete and to see a, nursing/physician report for any irregularities and/or action items. The documentation did not stipulate if the potential irregularity was reported to the nurse, or the physician, or to both. A review of the binder reported by the facility to contain all consultant pharmacist review reports with the Director of Nursing on April 3, 2026, at 12:25 PM revealed that there was no report for Resident 5's June 17, 2025, MRR. Progress note documentation by the consultant pharmacist dated September 16, 2025, at 3:02 PM revealed that the MRR was complete and to see a, nursing/physician report for any irregularities and/or action items. The documentation did not stipulate if the potential irregularity was reported to the nurse, or the physician, or to both. A, Note to Nursing, dated September 16, 2025, requested that the facility add parameters to separate the administration of two eye drop medications by three to five minutes because Resident 5 was receiving the eye drops at the same administration time. Information provided by the facility did not include a report to Resident 5's physician in response to the September 2025 MRR. Psychotropic and Sedative/Hypnotic Utilization by Resident review for records (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	updated between September 1 and 17, 2025, by the consulting pharmacist, indicated that Resident 5's use of Escitalopram Oxalate (Lexapro, an antidepressant medication) and Mirtazapine (Remeron, an antidepressant medication) were recommended for a formal assessment of their particular orders in October 2025. This directive was not forwarded to Resident 5's physician via a separate report. Interview with the Director of Nursing on April 3, 2026, at 12:59 PM confirmed that the physician did not respond timely to the MRR recommendation in May 2025. The interview also confirmed that the facility had no MRR report from the pharmacist to the physician for the June and September 2025 MRRs. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on clinical record review and staff interview, it was determined that the facility failed to ensure complete and accurate clinical documentation for 1 of 18 residents reviewed (Resident 4).Findings include: Review of Resident 4's medical history revealed a diagnosis list that included the following: heart failure, iron deficiency anemia, vitamin d deficiency, and gastrointestinal hemorrhage (bleeding). The current care plan for Resident 4 revealed the resident is at nutritional risk due to medical history, fluctuating weights, and variable intakes. An intervention included weigh per physician order for close monitoring. Review of the current physician orders for Resident 4 revealed no physician order for weight assessment as noted in the care plan. Dietary documentation for Resident 4 dated February 18, 2026, at 11:34 AM revealed that a reweight was completed with weight gain now noted (significant for 90 and 180 days). The documentation noted to follow with request for weekly weights for close monitoring. Facility documentation titled, Provider Notification Form, dated February 18, 2026, for Resident 4 revealed that resident had a weight gain and dietitian recommends weekly weights. The medical provider wrote a response of, Ok! which was dated February 19, 2026.A review of the recent weights in the electronic health record (EHR) for Resident 4 revealed that the facility staff documented that the resident was weighed on February 14, 2026, February 17, 2026, March 12, 2026, and April 2, 2026. There was no evidence in Resident 4's clinical record that weekly weights were completed as noted as indicated in the dietary documentation on February 18, 2026, and provider's approval on February 19, 2026. The above information was reviewed with the Nursing Home Administrator and Director of Nursing on April 1, 2026, at 2:00 PM. Facility staff provided documentation for Resident 4 titled, Weekly Weights, after it was brought to facility staff's attention as noted above. The documentation was a sheet of paper that included Resident 4 as well as 15 additional residents that were to have weekly weights and not part of any clinical record. The documentation noted that Resident 4 was weighed the weeks of February 24, 2026, March 3, 2026, March 10, 2026, March 17, 2026, March 24, 2026, and March 31, 2026. An interview with the facility on April 2, 2026, at 2:00 PM revealed that the Weekly Weights form containing multiple residents is handed into the Director of Nursing (DON) to review and then the DON passes the information onto the dietary staff. The form is not part of the clinical record. The weights are to be transcribed to the resident's clinical record and were not per the DON. 28 Pa. Code 211.5(f) Medical records

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F 0628 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on clinical record review and staff interview it was determined that the facility failed to ensure that the notice of transfer or discharge included the required contents for three of six residents reviewed for hospitalization concerns (Residents 2, 6, and 10). Findings include: Clinical record review for Resident 2 revealed nursing documentation dated March 5, 2026, at 7:45 PM that revealed that the registered nurse assessed Resident 2's pain and arranged for her transport to the hospital via emergency medical services. Nursing documentation dated March 6, 2026, at 2:56 AM revealed that Resident 2's responsible party (daughter) informed the facility that Resident 2 had a hip fracture and was admitted to the hospital. Review of a Discharge/Transfer Notice dated March 6, 2026, for Resident 2 revealed that the notice did not include a statement of the resident's appeal rights that included 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. The notice also did not correctly note the name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman. The notice errantly included the local county Ombudsman information in the paragraph stipulated to include the representative of the Office of the State Long-Term Care Ombudsman. The surveyor reviewed the above concerns regarding Resident 2's notice during an interview with the Nursing Home Administrator on April 3, 2026, at 11:45 AM. Clinical record review for Resident 6 revealed the resident was sent to the hospital on January 21, 2026, for a change in condition and returned later that day. There was no evidence that facility staff provided Resident 6, who was alert and oriented, with a copy of the written notice of transfer and bed-hold information as soon as practicable after the transfer only that the information was sent to the resident's responsible party. Clinical record review for Resident 10 revealed the resident was sent to the hospital on December 16, 2025, for a change in condition and was admitted . There was no evidence that facility staff provided the resident's responsible party with a copy of the written notice of transfer and bed-hold information as soon as practicable after the transfer, only that the information was signed by the resident. The facility was unable to provide any documentation for Resident 6 or Resident 10 that they notified both the resident and the resident's representative(s) of the above transfers. Further review of the Discharge/Transfer Notice dated January 21, 2026, for Resident 6, and December 16, 2025, for Resident 10, revealed that the notices did not include a statement of the resident's appeal rights that included 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. The notice also did not correctly note the name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman. The notice errantly included the local county Ombudsman information in the paragraph stipulated to include the representative of the Office of the State Long-Term Care Ombudsman. The above concerns related to Resident 6 and Resident 10 Discharge/Transfer Notice were reviewed with the Director of Nursing on April 3, 2026, at 11:45 AM. 483.15(c)(2)(iii)(3)-(6)(8)(d)(1)(2); 483.21(c)(2)(i)-(iii) Discharge ProcessPreviously cited deficiency 10/8/25 28 Pa. Code 201.14(a) Responsibility of license 28 Pa. Code 201.29(a) Resident rights

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Some	Post nurse staffing information every day. Based on a review of facility documentation and staff interview, it was determined that the facility failed to maintain the posted daily nurse staffing data for a minimum of 18 months for three of three months reviewed (January, February, and March 2026).Findings include: A review of the facility's binder that contained daily nurse staffing postings for January, February, and March 2026, revealed that the facility did not have postings for the following dates and/or shifts: January 1, 3, 9, 10, 11, 17, 18, 23, and 25, 2026February 5, 13 (third shift), 14, 15, 23, 27 (second and third shift), and 28 (third shift), 2026March 6 (second and third shifts), 7, 8, 13 (second and third shifts), 14, 15 (second and third shifts), 20 (second and third shifts), 28, and 29, 2026 Interview with the Nursing Home Administrator and the Director of Nursing on April 2, 2026, at 10:45 AM confirmed that the facility could not produce the documentation to confirm that 18 months of postings were maintained. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18 (b)(3)(e)(1) Management