STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395258	A. Building B. Wing	03/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Silver Lake Healthcare Center	905 Tower Road Bristol, PA 19007

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 41471 Based on review of clinical records, observations, review of facility policies and procedures and interviews with staff, it was determined that the facility failed to promptly notify resident's physician and representative of a change in skin condition of for one of 14 residents reviewed (Resident R2). Findings include: Review of undated facility policy titled Notification of Change in Condition, revealed The center must inform the resident, consult with the resident's medical practitioner and/or notify the residents' representative, authorized family member, or legal power of attorney/guardian when there is a change requiring such notification. The medical practitioner is promptly notified of significant changes in condition, and the medical record must reflect the notification, response, and interventions implemented to address the resident's condition. When a change in condition is noted, the nursing staff will contact the resident representative. Observation of Resident R2 on March 30, 2025, at 10: 34 a.m., with Employee E4, Licensed Nurse Supervisor, revealed a dark colored elevated area approximately 2 inches in diameter to the resident's anterior left foot. Employee E4 stated it could be a bruise or blood-filled blister. Interview with Employee E5, Nurse Aide, on March 30, 2025, at 11: 30 a.m. stated she saw the area two days ago and reported it to the Wound care nurse, Employee E3. Employee E5 stated she also saw this area on Saturday and that morning. Review of clinical record for Resident R2 revealed no documented evidence of the area identified on the resident's anterior left foot the area or the physician or resident/representative were notified of the area. Interview with Employee E1, Nursing Home Administrator, on March 30, 2025, at 2: 00 p.m. Administrator confirmed that there was no documented evidence in the clinical record to indicate the cause of the area such as an investigation or resident's physician was notified of the change in skin condition. 28 Pa. Code: 211.12(c)(d)(1)(2)(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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. 41471 Based on, review of facility policies and procedures, observations and interviews with staff, it was determined that the facility failed to ensure treatment and services were provided to the resident to prevent development of wounds met the professional standards of practice for 4 of 14 residents reviewed. (Resident R1, R2, R4 and R5). Findings include: Review of an undated facility policy titled Skin Care & Wound Management, revealed Develop a care plan for pressure ulcer prevention. Consider the following interventions for a resident at moderate risk. Add further interventions as indicated. A. Sensory Perception a. Evaluate areas of skin where the resident may have impaired sensation, such as feet. b. Instruct resident to notify staff of any changes in skin condition. D. Mobility c. Position with pillows/support devices to assist in maintaining position and comfort. d. Protect/elevate elbows and heels as indicated. G. Other c. Monitor treatment plans for diseases that impact sin impairment risk. 4. Revise intervention and/or goals as indicated. Observation of Resident R4 on March 26, 2025, at 10:25 a.m. with the wound care nurse, Employee E3 revealed the resident was lying in his bed. The heel lift boot was sitting on the wheelchair. Review of clinical record revealed no evidence that the resident refused the heel boots or the reason staff did not apply the heel boots. Further review of the clinical record revealed that the resident had left heel full thickness Kennedy terminal ulcer (a type of skin breakdown that occurs in the final stages of life, often appearing suddenly as a pear-shaped or butterfly-shaped area of discoloration) to the left heel. Observation of the Resident R1 on March 26, 2025, at 10:30 a.m. with the wound care nurse, Employee E3 revealed the resident had 2 wounds to the right lower extremity. There was a heel wound and a right dorsal wound. It was revealed the resident was wearing a heel boot to the right heel, but the left heel was flat on the bed without any offloading measures. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident R1's skin notes by the wound care practitioner dated December 25, 2024; January 3, 2025; January 8, 2025; January 16, 2025; January 30, 2025; and February 5, 2025 revealed the practitioner recommended to float heels while in bed. Observation of the Resident R2 on March 26, 2025, at 10:45 a.m. revealed that there was heel lift boot sitting on the top of air-conditioning unit. Observation of the Resident R2 on March 30, 2025, at 10:34 a.m. revealed that there was heel lift boot sitting on the top of air-conditioning unit. Review of clinical record revealed no evidence that the resident refused the heel boots, or the reason staff did not apply the heel boots. Observation of the Resident R5 on March 26, 2025, at 10:45 a.m. revealed that there was heel lift boot sitting on the floor. Resident was lying on the bed. 28 Pa Code 211.12(c) Resident care policies 28 Pa. Code: 211.12(c)(d)(1)(2)(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. 41471 Based on review of clinical records, observations, review of facility policies and procedures and interviews with staff, it was determined that the facility failed to ensure treatment and services were provided to the resident with bilateral lower extremity venous ulcer as recommended by the physician for one of 14 residents reviewed. (Resident R3) Findings Include: Review of wound care practitioners' recommendation dated March 19, 2025, revealed a recommendation to apply tubi-grip to lower extremity daily during the day and off at night. Review of wound care practitioners' recommendation dated March 26, 2025, revealed a recommendation to apply tubi-grip to lower extremity daily during the day and off at night. Observation of Resident R3 on March 30, 2025, at 11:00 a.m., with Employee E4, Licensed Practical Nurse Supervisor, revealed that the resident was sitting in her wheelchair. Her feet was on the floor. Resident was not wearing tubi grip or any compression measures to her lower extremity. It was observed that the resident had an ulcer to the left calf area. There was no dressing or wound care to the right leg. Continued observation revealed that there was new fluid filled blister to the right lower extremity. Interview with Employee E4, on March 30, 2025, at 11: 30 a.m. stated the tubi grips are applied for preventing swelling of the lower extremity and prevent development of ulcer. Employee E3 confirmed that the resident was not wearing tubi-grip or any compression measures to her lower extremity Review of physician orders for Resident R3 revealed that there was no order in her physician orders for tubi-grips as recommended by the practitioners. Review of Treatment Administration Record for Resident R3 revealed that there was no evidence that the resident was offered tubi-grip as recommended by the practitioner. 28 Pa. Code: 211.12(c)(d)(1)(2)(3)(5) Nursing services

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - 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** 41471 Based on the review of clinical records, facility policies, professional standards of practice, observations and staff interviews, it was determined that the facility failed to develop and implement care and services consistent with professional standards of practice to prevent the development of a pressure ulcer resulting in actual harm to Resident R1 who developed Stage II pressure ulcer to the right heel for one of 14 residents reviewed. Findings include: According to the US Department of Health and Human Services, Agency for Healthcare Research & Quality, the pressure ulcer best practice bundle incorporates three critical components in preventing pressure ulcers: Comprehensive skin assessment, standardized pressure ulcer risk assessment, and care planning and implementation to address the areas of risk. The American College of Physicians (ACP) is a national organization of internists who specialize in the diagnosis, treatment, and care of adults. Clinical Practice Guidelines indicate that the treatment of pressure ulcers should involve multiple tactics aimed at alleviating the conditions contributing to ulcer development (i.e. , support surfaces, repositioning, and nutritional support); protecting the wound from contamination and creating and maintaining a clean wound environment; promoting tissue healing via local wound applications, debridement, and wound cleansing; using adjunctive therapies; and considering possible surgical repair. Review of an undated facility policy titled Skin Care & Wound Management, revealed Develop a care plan for pressure ulcer prevention. Consider the following interventions for a resident at moderate risk. Add further interventions as indicated. A. Sensory Perception a. Evaluate areas of skin where the resident may have impaired sensation, such as feet. b. Instruct resident to notify staff of any changes in skin condition. D. Mobility c. Position with pillows/support devices to assist in maintaining position and comfort. d. Protect/elevate elbows and heels as indicated. G. Other c. Monitor treatment plans for diseases that impact sin impairment risk. 4. Revise intervention and/or goals as indicated. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of Resident R1's clinical record revealed Resident R1 was readmitted to the facility on [DATE], after hip fracture and ORIF (Open Reduction and Internal Fixation - surgical procedure used to treat severe fractures or dislocations by realigning the broken bones and stabilizing them with internal hardware, such as screws, plates, or rods). Resident's diagnoses include but not limited to following: Dementia (progressive degenerative disease of the brain) and cognitive deficit. Review of Resident R1's quarterly Minimum Data Set assessment (MDS-federally mandated standardized assessment process conducted periodically to plan resident care) dated November 8, 2024, revealed Resident R1 was independent for rolling left and right (ability to roll from lying on back to left and right side, and return to lying on back on the bed), sit to stand and mobility. This assessment was completed prior to the resident sustaining the fracture and subsequent surgical procedure. Continued review of MDS assessments revealed a significant change of status assessment dated [DATE], in which Resident R1 was assessed as requiring substantial assistance for rolling left and right also was dependent on staff for sit to stand. It was documented that the ambulation was not completed due to medical status. It was also documented in the MDS assessment the resident was at risk of developing pressure ulcers. Review of Resident R1's skin notes by the wound care practitioner dated December 25, 2024; January 3, 2025; January 8, 2025; January 16, 2025; January 30, 2025; and February 5, 2025 revealed the practitioner recommended to float heels while in bed. Review of Resident R1's clinical record failed to reveal documented evidence the facility provided offloading to resident heels as recommended by the wound care practitioner. Review of care plan for Resident R1 on March 26, 2025, failed to reveal evidence the facility updated resident's care plan with individualized interventions to address resident's decreased mobility status, increased staff assistance and higher risk for developing pressure ulcer. Review of nurse aide documentation from February 26, 2025 to March 10, 2025, for Resident R1's bed mobility revealed the resident was mostly dependent on staff for bed mobility activity. Review of Resident R1's skin note dated March 10, 2025, revealed, routine skin check was performed by Wound care provider on 03/10/25, wound care team observed the following skin alterations on patient, discoloration noted to right foot- dorsal surface, with full thickness, measuring approximately 2cm x 2.5cm, x 0.1cm, treatment provided, new order received to cleanse site with normal saline, pat dry with sterile gauze, apply medihoney, and wrap with rolling gauze, a skin alteration was also noted to right heel, approximately 0. 5cm x 1cm, x 0.1cm, treatment provided, new order received to cleanse site with normal saline, pat dry with sterile gauze, apply medihoney, and cover with bordered gauze. Review of Resident R1's skin note by the wound care practitioner dated March 17, 2025, revealed the resident was seen for right heel pressure ulcer and right dorsal wound. The etiology for right heel was pressure injury and noted as Stage 2 (ulcer involving loss of the top layers of the skin) pressure ulcer. The right heel wound measured 0.4 centimeters (cm) x 0.7cm x 0.1 cm. The right dorsal wound was an abrasion wound which measured 1cm x 0.7 cm x 0.1 cm. The practitioner recommended to float heels while in bed. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of Resident R1's skin note by the wound care practitioner dated March 24, 2025, revealed the resident was seen for right heel pressure ulcer and right dorsal wound. The etiology for right heel was pressure injury and was a stage 2 pressure ulcer. The right heel wound measured 0.4x 0.6 cm x 0.1 cm. The right dorsal wound was an abrasion wound which measured 1cm x 0.7 cm x 0.1 cm. The practitioner recommended to float heels while in bed. Observation of the resident on March 26, 2025, at 10:30 a.m. with the wound care nurse, Employee E3 revealed the resident had 2 wounds to the right lower extremity. There was a heel wound and a right dorsal wound. It was revealed the resident was wearing a heel boot to the right heel, but the left heel was flat on the bed without any offloading measures. Resident was also wearing a brace to right lower extremity which limited resident's movement. Interview conducted on March 26, 2025, at 10:30 a.m. with the wound care nurse, Employee E3 revealed the right dorsal wound was caused by a TED (Thrombo-Embolus deterrent (TED) stockings are also known as compression stockings or Anti-Embolism Stockings and are specially designed to help reduce risk of developing deep vein thrombosis (DVT) or blood clot in your lower leg after Surgery) stocking which was applied without an order. When the TED stockings were removed for skin check a wound was observed under the TED stocking. Review of Resident R1's clinical record and physician orders failed to reveal documented evidence the facility obtained an order for TED stocking and/or a removal schedule. There was also no cause of abrasion documented in the clinical record. Interview with Director of Nursing on March 26, 2025, at 2:00 p.m. revealed, it was the facility practice to find out root cause analysis (incident report) for skin alteration and implement corrective actions. However, there was no incident report completed for Resident R1. Interview with Nursing Home Administrator on March 26, 2025, at 2:00 p.m. confirmed there was no evidence the facility implemented wound practitioner's recommendation to off load heels and resident subsequently developed pressure ulcer to the heel. The facility failed to ensure that interventions to prevent the development of pressure ulcers were implemented which resulted in actual harm to Resident R1 who developed Stage II pressure ulcer to the right heel. 28 Pa. Code 211.10(c)(d) Resident care policies 28 Pa. Code 211.12(c)(d)(1)(3)(5) Nursing services

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough food/fluids to maintain a resident's health. 41471 Based on clinical record reviews and staff interviews, it was determined that the facility failed to implement interventions to maintain acceptable parameters of nutrition for two of 14 residents reviewed (Residents R6 and R7). Findings include: Review of undated facility policy entitled, Height and Weight, that . Compare weight to previous weight obtained. If a variance of 5 pounds or more is noted, reweigh resident to verify weight. Stable resident swill be weighed monthly thereafter, unless physician or diagnosis indicate otherwise, Unstable residents will be reviewed by IDT team to determine frequency of obtaining weight a. Update Interdisciplinary Care plan as needed. Weight loss concerns are reported to the practitioner and discussed at the weekly clinical meeting. Review of the weight record for Resident R6 on August 7, 2024, revealed that the resident weighed 159.0 lbs. (pounds). On September 16, 2024, the resident weighed 150 pounds which was a -5.66 % loss over one month and 10.2 % loss over 6 months. Review of the clinical record revealed that a nutritional assessment was not completed until September 27, 2024. Further review of the clinical record revealed that the resident was not reweighed in a timely manner to confirm the weight loss according to the facility protocol. There was no evidence that the facility increased weight/nutritional monitoring for Resident R6 in response to the weight loss. Review of the weight record for Resident R6 on October 23, 2024, revealed that the resident weighed 145.5 lbs.(pounds) which was a 8.5% loss over three months and 14.4% loss over 6 months which was triggered for significant weight loss. Review of the clinical record revealed that a nutritional assessment was not completed until October 28, 2024. However, it was documented that previous weight changes addressed in previous note, recent weight change not significant, intake average for meals 75%-100%. Continue current diet as ordered. Further review of the clinical record revealed that the resident was not reweighed in a timely manner to confirm the weight loss according to the facility protocol. There was no evidence that the facility increased weight/nutritional monitoring for Resident R6 in response to the weight loss. Review of the weight record for Resident R6 on October 30, 2024, revealed that the resident weighed 144.0 lbs.(pounds) which was a 9.4% loss over three months and 15.3% loss over 6 months which was triggered for significant weight loss. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the clinical record revealed that a nutritional assessment was completed on October 31, 2024. However, it was documented that weight change not new, has been addressed in previous note. Continued review revealed that the resident was not reweighed in a timely manner to confirm the weight loss and there was no evidence that the facility increased weight/nutritional monitoring for Resident R6 in response to the weight loss. Review of the weight record for Resident R6 on November 5, 2024, revealed that the resident weighed 142.0 lbs.(pounds) which was 5 % Loss over one month, 10.7% loss over three months and 12.3% loss over 6 months which was triggered for significant weight loss. Review of the clinical record revealed that a nutritional assessment was not completed until November 12, 2024. There was no evidence that the facility increased weight/nutritional monitoring for Resident R6 in response to the weight loss. Review of the weight record for Resident R6 on December 3, 2024, revealed that the resident weighed 139.5 lbs.(pounds) which was 10.7% loss over three months and 13.9% loss over 6 months which was triggered for significant weight loss. Review of the clinical record revealed that a nutritional assessment was not completed until December 18, 2024. Review of the weight record for Resident R6 on January 8, 2025, revealed that the resident weighed 139.0 lbs.(pounds) which was 14.2% Loss over 6 months which was triggered for significant weight loss. Review of the clinical record revealed that a nutritional assessment was not completed until January14, 2025. Review of clinical record for Resident R7 revealed that the resident was not weighed, obtained physician order for monthly weight, documented reason for not obtaining monthly weight or documented refusal of monthly weight appropriately from January 2024 to January 2025. Interview with Employee E6, Medical Record Nurse on March 30, 2025, at 2:00 p.m. confirmed that there was no order for monthly weight or monthly weight for Resident R7. 28 Pa. Code 211.12(c) Resident care policies 28 Pa. Code: 211.12(c)(d)(1)(2)(3)(5) Nursing services

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. 41471 Based on the review of clinical records, facility documentation, interview with staff, it was determined that the facility failed to ensure that nursing staff possessed the appropriate competencies and skill sets related to the care of residents with PICC line (a tube placed in a large vein in the neck, chest, groin, or arm to give fluids, blood, or medications or to do medical tests quickly) for two of two employee records reviewed. (Employee E7 and E8). Findings Include: Observation of Resident R8 on March 26, 2025, at 11:00 a.m., revealed that the resident had a left upper extremity PICC line insertion. There was no documentation on the dressing to indicate the date and time the dressing last changed. Review Resident R8's active physician order on March 26, 2025, revealed an order to measure external catheter length with dressing change. However, there was no evidence that the staff obtained or documented external catheter length. Observation of Resident R9 on March 26, 2025, at 10:00 a.m., revealed that the resident had a left upper extremity PICC line insertion. Resident stated staff did not change her dressing weekly. There was no documentation on the dressing to indicate the dressing change date. A request for PICC line care and management competency for Employee E8, Registered Nurse and E9, Licensed Nurse was requested to the Director of Nursing. Facility did not submit the PICC line care and management competency for Employee E7 and E8 during the survey. Interview with Registered Nurse, Employee E9 who was responsible for staff education stated facility did not complete competencies for PICC line dressing changes. 28 Pa. Code: 211.12 (d)(1) Nursing services 28 Pa. Code: 211.12(d)(5) Nursing services

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 41471 Based on the review of clinical records, facility policies, facility documentation, interview with staff, it was determined that the facility failed to follow acceptable standard of practice for medical record documentation for one of 14 residents reviewed. (Resident R6) Findings Include: Review of undated facility policy entitled, Height and Weight, revealed that Nurses will follow the basic standards of practice for documentation including but not limited to providing a timely and accurate account of resident information in the medical record, documenting legibly in English using only acceptable medical abbreviations. Timeliness and accuracy. a. Chart in real time when an event is occurring or shortly thereafter as is practicable. b. avoid over use of late entries. Late entries may be confusing and contradictory and only use sparingly. Review of meal intake documentation for Resident R6 dated November 1, 2024, to November 30, 2024, revealed that 25 of 30 documentation of breakfast and lunch intake/consumption documentation was completed at the same time of the day. There was no dinner documentation on November 13 and November 24. Review of meal intake documentation for Resident R6 dated December 1, 2024, to December 31, 2024, revealed that 18 of 31 documentation of breakfast and lunch intake/consumption documentation was completed at the same time of the day. There was no dinner documentation on December 15 and December 22. Review of meal intake documentation for Resident R6 dated January 1, 2025, to January 31, 2025, revealed that 12 of 31 documentation of breakfast and lunch intake/consumption documentation was completed at the same time of the day. There was no lunch and dinner documentation on January 19 and January 20. Review of meal intake documentation for Resident R6 dated January 28, 2025, to February 12, 2025, revealed that 8 of 16 documentation of breakfast and lunch intake/consumption documentation was completed at the same time. Interview with the Director of Nursing, Employee E2 on March 25, 2025, at 12:00 p.m. stated facility staff was expected to document in real time. 28 Pa. Code 211.5(d) Medical records.

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 41471 Based on observation, review of facility policy and procedure and interviews with staff, it was determined that the facility failed to maintain an effective infection control program related to the wound treatment and enhanced barrier precaution for 4 of 14 residents reviewed. (Resident R1, R6, R9 and R11) Findings include: Review of an undated facility policy, Enhanced Barrier Precaution, revealed that Communication to staff and visitors-post sign on the resident door indicating enhanced barrier precaution is required. Enhanced Barrier Precautions (EBP) refer to an infection control intervention designed to reduce transmission of multi-drug resistant organisms that employs hand hygiene, targeted gown and glove use during high contact resident care activities that include; Dressing, Bathing/showering, Transferring, Providing hygiene, Changing linens Changing briefs or assisting with toileting, Device care or use: central line, urinary catheter, feeding tube, tracheostomy ventilator, Wound care: any skin opening requiring a dressing. In general, gowns and gloves would not be recommended when performing transfers in common areas, such as dining or activity rooms, where contact is anticipated to be in shorter duration. Outside the resident's room, EBP should be followed when performing transfers or assisting during bathing. In a shared/ common shower room and when working with residents in the therapy gym, specifically when anticipating close physical contact while assisting with transfers and mobility. Residents are not restricted to their rooms or limited from participation in group activities. EBP is intended to be in place for the duration of the resident 's stay in the facility or until resolution of the wound or discontinuation of the indwelling medical device. EBP are indicated for residents with any of the following: Infection or colonization with a CDC targeted MDRO when contact precautions do not otherwise apply Wounds and/or indwelling medical devices (even if the resident is not known to be infected or colonized with a MDRO) Wounds generally include chronic wounds, not shorter-lasting wounds, such as skin breaks, or skin tears covered with an adhesive bandage (e.g., Band-Aid) or similar dressing Examples of chronic wounds include, but are not limited to pressure ulcers, diabetic venous stasis ulcers. Indwelling medical device examples include central lines including PICC, urinary catheters, feeding tubes, and tracheostomies. A peripheral IV line is not considered. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395258	A. Building B. Wing	03/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Silver Lake Healthcare Center	905 Tower Road Bristol, PA 19007

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Gowns, gloves, and hand sanitizer are readily accessible to staff. Observation of the facility second floor on March 26, 2025, at 10:20 a.m. revealed the following findings: Resident R6 was receiving tube feeding. Clinical record revealed that the resident had pressure ulcers. There was no sign at the door indicating enhanced barrier precaution. There was no personal protective equipment available in/near resident's room. Resident R11's door sign revealed that the resident was on enhanced barrier precaution. There was no personal protective equipment available in/near resident's room. Resident 9's door sign revealed that the resident was on enhanced barrier precaution. There was no personal protective equipment available in/near resident's room. Resident 1's door sign revealed that the resident was on enhanced barrier precaution. There was no personal protective equipment available in/near resident's room. Resident 4's door sign revealed that the resident was on enhanced barrier precaution. There was no personal protective equipment available in/near resident's room. A wound care observation of Resident R1 on March 26, 2025, at 10:30 a.m. with the wound care nurse, Employee E3 revealed the door sign at resident's door revealed that the resident was on enhanced barrier precaution. Employee E3 started the wound care, positioned the resident and removed the soiled/old dressings from resident's lower extremity with out wearing a gown as recommended by the enhanced barrier precaution sign and facility policy. Employee E3 only worn the gown after cleaning the wounds. Interview with Employee E3 on March 26, 2025, at 10:45 a.m. confirmed the above findings. 28 Pa Code 211.12 (d)(1)(5) Nursing services