STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395375	A. Building B. Wing	07/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Swaim Health Center	210 Big Spring Road Newville, PA 17241

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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 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 interviews, it was determined that the facility failed to ensure that the resident assessment accurately reflected the resident's status for three of 19 residents reviewed (Residents 5, 23, and 47). Findings include: Review of Resident 5's clinical record revealed diagnoses that included diabetes mellitus (chronic condition that affects the way your body metabolizes sugar [glucose], leading to high blood sugar levels) and hereditary and idiopathic neuropathy (a group of inherited disorders that affect the peripheral nervous system and a type of nerve damage where the cause remains unknown despite thorough testing, leading to symptoms like numbness, pain, and balance issues). Review of Resident 5's Comprehensive MDS (Minimum Data Set - an assessment tool to review all care areas specific to the resident such as a resident's physical, mental or psychosocial needs) with the assessment reference date (last day of the assessment period) of October 4, 2024, indicated in Section N. Medications that she was not coded as receiving an anticonvulsant medication during the assessment period. Review of Resident 5's October 2024 Medication Administration Record (MAR) revealed that she had received gabapentin (an anticonvulsant medication used to treat neuropathy) during the assessment period. Email communication received from the Nursing Home Administrator (NHA) on July 2, 2025, at 10:38 AM, indicated that Resident 5's MDS had been corrected. During a staff interview with the NHA and the Director of Nursing (DON) on July 2, 2025, at 11:35 AM, the NHA indicated that she would expect a resident's MDS's to be completed accurately. Review of Resident 23's clinical record revealed diagnoses that included dementia (a chronic disorder of the mental processes caused by brain disease, and marked by memory disorders, personality changes, and impaired reasoning) and anxiety disorder (a mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities). Review of Resident 23's Quarterly MDS with the assessment reference date of February 21, 2025, revealed in Section N. Medications that he was coded as receiving a hypnotic medication in the assessment period. (continued on next page)

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

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 23's February 2025 MAR failed to reveal that he had received a hypnotic medication. Email communication received from the NHA on July 1, 2025, at 4:34 PM, confirmed that Resident 23's MDS had been coded in error and that a correction was completed. During a staff interview with the NHA and the DON on July 2, 2025, at 11:35 AM, the NHA indicated that she would expect a resident's MDS's to be completed accurately. Review of Resident 47's clinical record revealed diagnoses that included type 2 diabetes mellitus and edema (swelling caused by too much fluid trapped in the body's tissue). Resident 47 was admitted to the facility on [DATE]. Review of facility wound care tracking revealed that Resident 47 has an unstageable pressure injury (type of sore that is characterized by the presence of non-viable tissue, which obscures wound bed making it impossible to measure the depth or stage of the ulcer) to his right heel that originated on November 22, 2024. Review of Resident 47's February 12, 2025, quarterly and May 11, 2025 comprehensive MDS assessments revealed that each of them was coded to indicate that he had an unstageable pressure ulcer/injury, but that it was already present upon admission to the facility. Email correspondence received from the NHA on July 1, 2025, at 5:09 PM, confirmed that the aforementioned MDS assessments were coded in error and were being corrected. 28 Pa Code 211.12 (d)(3)(5) Nursing Services

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policies, clinical record reviews, and staff interviews, it was determined that the facility failed to ensure care and services were provided in accordance with professional standards of practice to meet each resident's physical, mental, and psychosocial needs for three of 16 residents reviewed (Residents 5, 22, and 55). Findings include: Review of facility policy, titled Wound Care, with a last review date of August 14, 2024, revealed, in part, 15. Treatments will be performed by personnel in accordance with licensure practice acts. Review of facility policy, titled Intravenous Device Care, with a last review date of August 14, 2024, revealed, in part, 3. Intravenous Care will be documented in the medical record, Electronic Medication Administration Record, and/or Electronic Treatment Administration Record. Section titled PICC Line Care, indicated Intermittent Infusion - Change tubing and needleless connection devices every 24 hours; Dressing Change - Change transparent dressing and caps weekly and PRN [as needed]; and Measure External PICC Catheter Length - Upon insertion and weekly with dressing change. Review of facility policy, titled Change in Medical Condition, last approved December 24, 2024, revealed, [company] facilities shall provide notice of changes in medical condition related to but not limited to CHF [Congestive Heart Failure] .and other care issues in a timely manner meeting the requirements of accrediting agencies and federal and state agencies. Review of Resident 5's clinical record revealed diagnoses that included diabetes mellitus (the body's ability to produce or respond to the hormone insulin is impaired, resulting in abnormal metabolism of carbohydrates and elevated levels of glucose in the blood and urine) and hereditary and idiopathic neuropathy (a group of inherited disorders that affect the peripheral nervous system and a type of nerve damage where the cause remains unknown despite thorough testing, leading to symptoms like numbness, pain, and balance issues). Review of Resident 5's clinical record revealed that she was diagnosed with a diabetic foot ulcer on March 17, 2024. Review of Resident 5's current physician orders revealed an order for Left great toe: twice daily cleanse with wound cleanser; pat dry; apply skin prep to periwound (surrounding skin), and air dry. Cover wound bed with collagen (cut to fit) then calcium alginate (cut to fit). Secure with bordered gauze (island dressing) for wound healing< dated June 23, 2025. Review of order history revealed that this wound care was originally ordered on April 15, 2025. Further review of Resident 5's current physician orders revealed an order for monitor every shift foot cradle, ensure blankets are not tucked, in every shift date May 6, 2025. Review of Resident 5's Treatment Administration Records (TAR) for April 2025 through current revealed the following: (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	April 21 wound care was not signed as completed on 3-11 (evening) shift; May 2 and 8 wound care was not signed as completed on 7-3 (day) shift; May 8 foot cradle check was not signed as completed on 7-3 (day) shift; May 11 foot cradle check was not signed as completed on 11-7 (night) shift; June 2 wound care was not signed as completed on 7-3 (day) shift; June 12, 16, 17, 22, 23, and 29 wound care was not signed as completed on 3-11 (evening) shift; and June 12 and 17 foot cradle check was not signed as completed on 3-11 (evening) shift. During a staff interview with the Nursing Home Administrator (NHA) and Director of Nursing (DON) on July 2, 2025, at 11:35 AM, the DON confirmed she had no additional information to provide. She further confirmed that nursing staff should have provided Resident 5's wound care and foot cradle checks as ordered and should have documented all care accordingly. Review of Resident 22's clinical record revealed diagnoses that included congestive heart failure (chronic condition where the heart is unable to pump blood effectively to meet the body's needs, which can lead to a buildup of fluid in the lungs and other parts of the body) and Parkinson's disease (movement disorder that affects the nervous system and worsens over time). Review of Resident 22's physician orders revealed an order for daily weights in the morning, report a 2 pound weight gain overnight or a 5 pound weight gain in one week to provider to determine if Resident needs additional as-needed lasix (diuretic medication), starting February 27, 2025. Review of Resident 22's May and June 2025 weight documentation revealed that a 2 pound or greater weight gain was recorded overnight on the following dates: May 12th to the 13th, 15th to the 16th, 17th to the 18th, 24th to the 25th, 29th to the 30th; and June 17th to the 18th, and 28th to the 29th. Review of Resident 22's clinical record failed to reveal evidence that the provider was notified of the weight gain per physician orders on the aforementioned dates. During an interview with the DON on July 2, 2025, at 11:52 AM, she revealed that she was unable to provide any additional evidence that the provider was notified of Resident 22's weight gain as ordered. She also revealed the expectation that this should have occurred. Review of Resident 55's clinical record revealed that she was admitted to the facility on [DATE], with diagnoses that included infection reaction due to left hip prosthesis (artificial devices that replace missing or damaged body parts), unspecified pain, and hypertension (high blood pressure). Further review of Resident 55's clinical record revealed that she had a PICC (peripherally inserted central catheter-a long, thin tube that's inserted through a vein in the arm and passed through to the larger veins near the heart used to give medications or liquid nutrition) to receive intravenous antibiotics for the surgical infection of her left hip. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 55's current physician orders revealed the following orders: Cefazolin 2 gram intravenous (IV) solution 2 gram in 100 milliliters of normal saline solution (NSS) three times a day; Curos caps use as directed with IV's three times a day; Ultrasite valve CSU100 as directed with dressing change on Saturdays; IV sodium chloride 0.9% solution mini-bag spike and activate each 2 gram vial of cefazolin in 100 ml NSS and infuse over minutes [no minutes specified in order] every 8 hours; Normal Saline flush 10 ml as directed with cefazolin order three times a day; Zyno administration set (tubing) as directed with cefazolin order three times a day; PICC dressing change every week- change PICC line transparent dressing and caps Saturday and as needed if soiled, wet, or loosened; and measure PICC catheter length with every dressing change document length in comment. Review of Resident 55's June 2025 Medication Administration Record (MAR) revealed the following: June 15 at 2:01 PM: cefazolin, Zyno administration set, and saline flush were blank; June 15, at 10:01 PM: saline flush and Zyno administration set were blank; June 20, at 06:01 AM: cefazolin, saline flush, and Zyno administration set were blank; June 24, at 2:01 PM: Curos caps was blank; June 24, at 10:01 PM: cefazolin, IV sodium chloride 0.9% solution mini-bag spike and activate, saline flush, Zyno administration set, Curos caps were blank; June 25, at 2:01 PM: IV sodium chloride 0.9% solution mini-bag spike and activate, and Curos caps were blank; and June 26, at 2:01 PM: cefazolin, IV sodium chloride 0.9% solution mini-bag spike and activate, Zyno administration set, saline flush, and Curos caps were blank. Review of Resident 55's June 2025 TAR revealed that the PICC dressing change was marked N on June 20, 2025, and comment indicated that it was not done since it was due on Saturday; and that the measurement of the PICC line was blank and not signed as completed. In addition, the PICC dressing change entry was signed as completed on June 27, 2025, but the measurement of the PICC line was documented as 0. Review of Resident 55's clinical record progress notes revealed a nurse's note by a Registered Nurse that indicated the PICC line dressing was changed on Saturday, June 21, 2025, but the note failed to include the PICC line measurement. Email communication received from the DON on July 1, 2025, at 5:34 PM, indicated we did change her orders to ensure the dressing change and measurement is on Friday to coincide with it last being done on 06/27/2025. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a staff interview with the NHA and DON on July 2, 2025, at 11:36 AM, the DON confirmed that there were multiple missing entries in Resident 55's MAR and TAR for June 2025 and said there was no additional information to provide. She said that she would expect staff to have administered Resident 55's antibiotic and that it would be documented accordingly. The DON indicated that she could not locate any information in Resident 55's hospital records of the length of her PICC line. She confirmed that staff should have measured residents PICC line on admission and weekly as per facility policy and physician orders. She confirmed that the documentation of the PICC line measurement on June 27, 2025, was recorded as 0 and that would not be an accurate measurement as a PICC should have an external portion to measure. 28 Pa. Code 201.18(b)(1) Management 28 Pa. Code 211.10(c) Resident care policies 28 Pa. Code 211.12(d)(1)(2)(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. Based on policy review, clinical record review, and staff interviews, it was determined that the facility failed to ensure that residents received necessary treatment and services, consistent with professional standards of practice, to promote healing and prevent infection of a pressure ulcer for two of four residents reviewed for pressure ulcers (Residents 10 and 47). Findings Include: Review of policy, titled Wound Care, last approved December 24, 2024, revealed, Care of wounds is provided in accordance with current research and practice guidelines in order to facilitate healing and/or provide comfort and provide symptom control as appropriate .Treatments will be performed by personnel in accordance with licensure practice acts. Review of Resident 10's clinical record revealed diagnoses that included chronic pain and muscle weakness. Review of facility wound care tracking revealed that Resident 10 had stage 3 pressure injuries (full-thickness skin loss exposing underlying fat tissue) to both his left and right heels. Review of Resident 10's May 2025 TAR (Treatment Administration Record) revealed a physician order to apply Betadine swabsticks (used to treat or prevent bacterial infections) to both the left and right heels twice daily starting April 1, 2025, and ending May 30, 2025. Further review of Resident 10's May 2025 TAR revealed that it was not documented that this treatment was done on May 10 and 29, 2025, evening shifts. Review of Resident 10's June 2025 TAR revealed a physician order to cleanse the right heel wound with mild soap and water, apply skin prep (used to form a protective film or barrier) to the periwound (tissue surrounding a wound), apply medical grade honey to the wound bed, cover with calcium alginate (absorbs drainage and forms a moist gel), and secure with bordered gauze (absorptive dressing) twice daily starting June 23, 2025. Further review of Resident 10's June 2025 TAR revealed that it was not documented that this treatment was done on June 27 and 30, 2025, evening shifts. Review of Resident 47's clinical record revealed diagnoses that included type 2 diabetes mellitus (chronic condition that affects the way your body metabolizes sugar [glucose], leading to high blood sugar levels) and edema (swelling caused by too much fluid trapped in the body's tissue). Review of facility wound care tracking revealed that Resident 47 had an unstageable pressure injury (type of sore that is characterized by the presence of non-viable tissue which obscures wound bed making it impossible to measure the depth or stage of the ulcer) to his right heel. Review of Resident 47's May 2025 TAR revealed a physician's order to clean the right heel with soap and water, paint with betadine, and cover with bordered gauze each shift starting April 28, 2025, and ending May 5, 2025. (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 Resident 47's May 2025 TAR revealed that it was not documented that this treatment was done on May 2, 2025 day shift. Review of Resident 47's June 2025 TAR revealed a physician's order to cleanse his right heel with normal saline solution, pat dry, and paint with betadine three times per day, starting June 9, 2025. Further review of Resident 47's June 2025 TAR revealed that it was not documented that this treatment was done on June 10, 2025, at the scheduled 2:00 PM time, and on June 17 and 27, 2025, at the scheduled 8:00 PM time. During an interview with the Nursing Home Administrator on July 2, 2025, at 1:03 PM, she confirmed that they were unable to provide any additional information on this missing wound care documentation for Residents 10 and 47, and that she would expect that wound care would have been documented. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. Based on clinical record review and staff interviews, it was determined that the facility failed to ensure proper monitoring for acceptable parameters of hydration and nutritional status for one of three residents reviewed for nutrition (Resident 10). Findings include: Review of Resident 10's clinical record revealed diagnoses that included chronic pain and muscle weakness. Review of Resident 10's weight documentation revealed that he experienced a significant weight loss of 9. 52% between May 1, 2025, and June 2, 2025. Review of dietician progress notes dated June 3, 2025, revealed acknowledgement of the weight loss and a plan to monitor his weight weekly for one month, until July 3, 2025. Review of Resident 10's physician orders revealed an order to weigh weekly on Tuesdays through July 3, starting on June 10, 2025, and ending on July 3, 2025. Review of Resident 10's clinical record failed to reveal that a weight was recorded on June 24, 2025. Review of Resident 10's June 2025 TAR (Treatment Administration Record) revealed a physician's order for an enhanced shake (prepared to provide additional nutritional value) at 10:00 AM, 3:00 PM, and at bedtime daily starting June 10, 2025. Further review of Resident 10's June 2025 TAR revealed that the enhanced shake was not documented as being given on June 13 at 3:00 PM, and on June 13, 22, and 27 at bedtime. During an interview with the Nursing Home Administrator (NHA) on July 2, 2025, at 11:48 AM, she revealed she was not able to provide any additional information on the missing weight documentation for June 24, 2025. She also revealed the expectation that this weight should have been obtained and recorded. During a later interview with the NHA on July 2, 2025, at 1:03 PM, she revealed she was not able to provide any additional information regarding Resident 10's missing enhanced shake documentation, and that she would have expected it to be documented. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services