STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395400	A. Building B. Wing	06/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Susquehanna Health and Wellness Center	745 Old Chickies Hill Road Columbia, PA 17512

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based upon clinical record review, staff interviews, and observations, it was determined that the facility failed to ensure residents are provided with dignity while receiving care for one of 33 residents reviewed (Resident 156).Findings include:Review of Resident 156's diagnosis list revealed diagnoses including Parkinson's Disease (progressive disease of the central nervous system characterized by tremors, muscle weakness and unsteady gait), seizures and anxiety disorder).Review of Resident 156's clinical record revealed Resident 156 is receiving hospice services.Observation on June 15, 2026, at 9:52 a.m. revealed Resident 156 sitting in a Broda chair in the hallway near the B Wing nurses' station.Further observation on June 15, 2026, in the hallway near the nurses' station revealed that a hospice nurse was standing near Resident 156 and conducting a comprehensive physical examination of Resident 156 including taking blood pressure readings, pulse oximeter readings and questioning Resident 156 regarding resident's overall health and pain levels.Observation on June 15, 2026, at 10:00 a.m. revealed Resident 156's hospice nurse received a face-time phone call from the hospice agency nurse practitioner at the B Wing nurses' station. This call was also placed on speaker phone.Further observation of the phone call revealed the hospice nurse and the hospice nurse practitioner speaking via facetime and speaker phone about Resident 156's overall health and his continuing need for hospice services. This face-time phone conversation consisted of discussions including continence, pain, seizures, medication doses, diet and fluid intake. Further observation of the phone call also revealed the hospice nurse practitioner requesting an arm circumference measurement which the hospice nurse obtained while in the hallway at the nurses' station. Further observation of this phone call revealed the hospice nurse practitioner asking the hospice nurse questions regarding Resident 156's diet and nutrition intake. The hospice nurse then called out to a nurse aid who was walking by and asked about the quantity of food consumed by Resident 156 daily.The face-time phone call ended at approximately 10:19 a.m.Interview with the Nursing Home Administrator on June 15, 2026, at 10:30 a.m. revealed that the above conversations and subsequent phone call should not have occurred in the hallway at the nurses' station as it does not provide dignity in the care setting for Resident 156.28 Pa. Code 211.12(c)(d)(3) 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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based upon clinical record review and facility documentation, it was determined that the facility failed to ensure notification to the State ombudsman's office occurred for hospital transfers for two of thirty-three residents reviewed. (Resident 18 and Resident 25).Findings include:Findings Include: Review of Resident 18's clinical record revealed Resident 18 was transferred to an acute care facility on February 7, 2026, and readmitted to the nursing facility on February 18, 2026. Further review of Resident 18's clinical record revealed Resident 18 was also transferred to an acute care facility on March 23, 2026, and returned to the nursing facility on March 31, 2026. Review of facility documentation failed to reveal evidence that the facility notified the State Ombudsman's office of Resident 18's two transfers and admissions to an acute care facility. Interview with the Nursing Home Administrator on June 17, 2026, at approximately 10:00 a.m. confirmed that the State Ombudsman's office was not properly notified of the transfers. Review of Resident 25's clinical record revealed Resident 25 was transferred to an acute care facility on April 26, 2026, and subsequently admitted with a diagnosis of pneumonia. Further review of Resident 25's clinical record reveals that Resident 25 returned to the facility on April 28, 2026. Review of facility documentation failed to reveal evidence that the facility notified the State Ombudsman's office of Resident 25's admission to an acute care facility. Interview with the Nursing Home Administrator on June 17, 2026, at approximately 10:00 a.m. confirmed that the State Ombudsman's office was not properly notified of the transfers. 28 Pa. Code 211.5(b) Medical Records

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and staff interview it was determined the facility failed to accurately assess residents for two of two residents reviewed. (Residents 24 and 149)Findings Include: Review of Resident 24's clinical record reviewed Resident 24 was admitted to the facility on [DATE] with diagnosis of chronic respiratory failure.Further review of Resident 24's clinical record revealed resident was discharged to an acute care facility on January 28, 2026.Further review of Resident 24's clinical record failed to reveal evidence that a discharge MDS (periodic assessment of resident needs) was completed upon discharged .Review of Resident 149's clinical record revealed resident was admitted [DATE], and discharged [DATE].Further review of Resident 149's clinical revealed that a Discharge MDS (Minimum Data Set - periodic assessment of resident needs) was not completed.Interview with Licensed Employee E5 on June 17, 2026 at 2:15 p.m. confirmed that no discharge MDS was completed for Resident 24 and Resident149 after discharge from the facility.The above information was conveyed to the Nursing Home Administrator on June 17, 2026 at 12:00 p.m.28 Pa Code 211.5(f) Clinical Records28 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 resident interview, review of clinical records, and interviews with staff, it was determined that the facility failed to provide timely care and services for two of 33 residents reviewed (Residents 2 and 11). Findings include:Findings Include: Review of Resident 2's clinical record finds an SBAR (Situation, Background, Assessment, Recommendation) Summary on June 12, 2026, at 11:24 p.m. that states, 2246 Notified by staff that resident was having a seizure, resident had tonic-clonic movements, with muscle spasms, lasting 20 minutes in bed . PRN (as needed) seizure med was not available from pharmacy . Notified on call provider, ordered for resident to be sent to ER, 911 was called. Further review of Resident 2's electronic medication administration on June 12, 2026, record reveals that there was not an administration of Nayzilam Nasal Solution (Anticonvulsant) which was ordered as needed for breakthrough seizures. Further review of Resident 2's progress notes on June 12, 2026, at 11:24 p.m. finds that, EMT came at 2315 gave resident 2 rounds of IV versed resident was still seizing. Interview with the Director of Nursing (DON) on June 17, 2026, at approximately 9:50 a.m. reveals that the nurse assigned to Resident 2 on June 12, 2026, was on break at the time Resident 2 began seizing. The nurse covering during the break did not have the keys to access the medication cart that contained Resident 2's PRN seizure medication and was unable to locate the original nurse to obtain them. The covering nurse then contacted the DON via phone for instructions on how to access additional cart keys from the DON's office. While the DON was on the phone, EMS arrived and began treating Resident 2. Further interview with the DON on June 17, 2026, at approximately 10:30 a.m., finds that no investigation was completed nor statements from staff obtained. Interview with Resident 11 on June 15, 2026, at 1:13 p.m. revealed that resident was having pain in both knees. Review of Resident 11's physician's assistant note of May 19, 2026, revealed that given the resident's persistent pain recommending still to get CT [computed tomography also called a CAT scan, is a medical imaging technique that combines multiple X-ray images taken from different angles to produce detailed 3D images of bones, organs, blood vessels, and soft tissues] scans however referring to orthopedics. Review of progress note of May 26, 2026, revealed resident was seen by the physician's assistant on May 19, 2026, with new recommendations approved by the CRNP (certified registered nurse practitioner). New order for CT scan bilateral knees and ortho (orthopedics) referral. Review of physician's order dated May 26, 2026, indicated refer to orthopedics related to bilateral knee pain and CT scan for left and right knee without contrast. Order was faxed to CT facility. Review of progress note of May 29, 2026, revealed resident went to appointment for CT scan of bilateral knees, but facility received a call that a written order was needed. Review of physician's assistant note of June 2, 2026, revealed that resident was seen for bilateral (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	knee pain and resident indicated the pain was still present. Resident stated he/she went to get the CT scans on his/her knees, however, did not have scans. Note indicated that CT scan appointment was made for 5/27 however he/she did not get it done because there was no order. Will await CT scan to be completed. There is also an order to have her/him follow up with orthopedics and will see patient after that. Recommendations indicated to reschedule/reorder CT scan of bilateral knees, refer to orthopedic appointment. Review of order dated June 1, 2026, indicated CT without contrast to bilateral knees. Interview with the Director of Nursing (DON) on June 17, 2026, at 11:44 a.m. confirmed that the resident went for the CT scan on May 26, 2026, but it was not completed due to the order not having a diagnosis code, so the CT scan was reordered. The DON confirmed that the the appointment for orthopedics was scheduled today (22 days after the initial order) and that the CT scan was rescheduled today (15 days after the reorder). 28 Pa. Code 201.14(a) Responsibility of licensee 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 staff interviews, clinical record review, and facility documentation review it was determined the facility failed to ensure that one of five residents reviewed was free from accidents and provided adequate supervision for Resident 12. Review of Resident 12's diagnosis sheet revealed diagnoses type 2 diabetes (insufficient production of insulin, causing high blood sugar), and Alzheimer's Dementia (a progressive disease that destroys memory and other important mental functions). Review of Resident 12's June 2026 Medication Administration Record revealed an order for Metformin HCl Tablet 500 MG Give 1 tablet by mouth two times a day. Review of facility documentation revealed that on June 12, 2026, Resident 12 was administered crushed Metformin HCL tablet 500mg in coffee by Licensed Nursing Employee E6. Licensed Nursing Employee E6 then failed to observe Resident 12 until they had finished the coffee with the medications crushed inside. Resident 12 drank some of the coffee with the medication and set the coffee cup on the table. Licensed Nursing Employee E6 then failed to observe Resident 12 until they had finished the coffee with the medications crushed inside. Resident 170 went over to the table, took the cup and drank Resident 12's coffee. Review of Resident 170 progress notes revealed a nursing entry dated June 12, 2026, at 7:18 p.m. stating Resident 170 got up and went to this resident's table and took the coffee and when staff attempted to intervene and retrieve the cup from her, she gulped down the entire contents. Writer observed pill fragments in the bottom of the cup after she sat it down. MD (medical doctor) notified, new orders for obtain vitals for alert charting q (every) shift x3days, obtain blood sugar q shift x3 days. RP (responsible party) updated, DON (Director of Nursing) notified. Further review of Resident 12's facility documentation revealed that there was no supervision for Resident 12 while taking medication to ensure all medication had been administered. Review of Resident 12's active care plan failed to reveal a care plan or interventions for putting crush medication in coffee. Interview with the Director of Nursing on June 17, 2026, at 1:20 p.m. confirmed the above findings. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18(b)(1)(3)(e)(1) Management

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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 facility policy, clinical record review, and staff interview, it was determined that the facility failed to obtain and monitor weights for one of eight residents reviewed for nutrition (Resident 45).Findings Include:Review of facility policy Weight Assessment and intervention revised September 2008 revealed that .Negative trends will be evaluated by the treatment team whether or not the criteria for significant weight change has been met. Interventions for undesirable weight loss shall be based on careful consideration.Review of Resident 45's clinical record revealed recorded weights of 151.4 pounds January 7, 2026; 140.2 pounds February 2, 2026, with a reweight on February 18, 2026, of 162 pounds; 140.4 pounds March 4, 2026.Further review of Resident 45's clinical record revealed a dietary note dated March 4, 2026, indicating the resident's weight. Further review of the same dietary note failed to reveal recommendations to address the weight loss from January 7, 2026, to February 2, 2026 (loss of 11.2pounds or 7.40% in one month).Interview with Employee E4 on June 17, 2026, at 11:39 a.m. confirmed that further dietary interventions should have been implemented to address Resident 45's weight loss.28 Pa. Code 211.5(f) Clinical Records28 Pa. Code 211.10(c) Resident Care Policies28 Pa. Code 211.12(d)(1)(3)(5) Nursing Services

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based upon medication insert review, observation, and staff interview it was determined that the facility failed to ensure medications were labeled with open and expiration dates for three of six medication carts observed (A South Medication Cart, A South Back Medication Cart and B South Back Medication Cart).Findings include:Review of medication packaging inserts for Novolog (short acting) Insulin and Lantus (long acting) Insulin revealed that Novolog Insulin Pens and Lantus Insulin Pens are to be refrigerated until opened. If unrefrigerated, the pens must be marked with the date of removal from the refrigerator and used within 28 days.Observation of the A South Medication Cart on June 17, 2026, at 11:00 a.m. revealed three unopened and undated Novolog Insulin Pens and two unopened and undated Lantus Insulin Pens.Observation of the A South Back Medication Cart on June 17, 2026, at 11:08 a.m. revealed one opened and undated Novolog Insulin Pen.Observation of the B South Back Medication Cart on June 17, 2026, at 11:14 a.m. revealed one unopened and undated Novolog Insulin Pen; one opened and undated Novolog Insulin Pen and one opened and undated Lantus Insulin Pen.Interview with the Nursing Home Administrator and Director of Nursing on June 17, 2026, at 12:00 p.m. confirmed that the above insulin pens should have been marked with open or unrefrigerated dates.28 Pa. Code 211.12(c)(d)(3) Nursing Services

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of clinical records, and staff and resident interviews, it was determined that the facility failed to ensure that a resident was assessed by a dentist for one of one resident. (Resident 164)Findings include: Review of Resident R164's clinical record revealed the resident was admitted to the facility on [DATE], with a diagnosis of type 2 diabetes (insufficient production of insulin, causing high blood sugar), and congestive heart failure (excessive body/lung fluid caused by a weakened heart muscle). Interview on June 16, 2026, at 9:33 a.m. with Resident R164 revealed the resident does not have dentures and had requested dentures several times. Review of Resident R164's clinical record revealed no evidence that the facility arranged for or followed up on dental services to obtain dentures following the request. Interview on June 17, 2026, at 10:22 a.m. with Director of Social Services confirmed there was no documentation about further dental consults for Resident R164. 28 Pa. Code 211.12(d)(1)(5) Nursing services

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on interviews with residents, review of facility policy, observations, and interviews with staff, it was determined that the facility failed to serve food that was at an appetizing temperature on one of four units (B wing - Countryside). Findings include:An interview held with alert and oriented residents on June 15, 2026, at 10:00 a.m. revealed that food is cold for all meals. Review of facility policy, Food Presentation, undated, indicated foods will be served at proper temperatures. Hot foods hot and cold foods cold. A test tray conducted on June 16, 2026, on B-wing Countryside, in the presence of Employee E3, revealed that the meal cart left the kitchen at 12:03 p.m. Food temperatures taken at 12:37 p.m. after all residents had been served revealed the following: [NAME] Pilaf - 119.8 degrees FahrenheitCrab Cake - 123.7 degrees FahrenheitMixed Vegetables 109.0 degrees Fahrenheit Interview at that time with Employee E3 indicated that food could be a little hotter. 28 Pa. Code 201.14(a) Responsibility of licensee