

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395494	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/13/2026
NAME OF PROVIDER OR SUPPLIER Slate Belt Health & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 701 Slate Belt Blvd, Rd 3 Bangor, PA 18013	
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 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 on clinical record review and observation, it was determined that the facility failed to provide assistance with dining in a manner that promoted and maintained dignity for two residents in one of two dining rooms. (Residents 77, 106) Findings include: Clinical record review revealed that Resident 77 had diagnoses that included Parkinson's disease, dementia, and dysphagia (difficulty swallowing). Review of the Minimum Data Set (MDS) assessment, dated January 4, 2026, revealed that the resident had cognitive impairment and required assistance from staff with eating. Review of Resident 77's care plan revealed that the resident was at increased nutrition and hydration risk with an intervention for staff to encourage oral intake and assist with dining. On January 12, 2026, 12:05 p.m. through 12:18 p.m., Nurse Aide (NA) 2 was observed standing to assist Resident 77 to eat lunch, while the resident was seated in the wheelchair. Clinical record review revealed that Resident 106 had diagnoses that included benign neoplasm of the brain, cortical blindness (partial or total loss of vision due to damage to the brain's occipital cortex), and encephalopathy (diffuse disease of the brain that alters brain function or structure). Review of the MDS assessment, dated January 8, 2026, revealed that the resident had mild cognitive impairment and required assistance from staff with eating. Review of Resident 106's care plan revealed that the resident was at increased nutrition and hydration risk and had a self-care deficit with interventions for staff to encourage intake and assist with meals for safety. On January 12, 2026, 12:05 p.m. through 12:18 p.m., Resident 106 was observed in the dining room and eating independently. Fries and pulled pork had fallen onto his legs and the floor. NA 2 was standing while assisting Resident 77, who was seated next to Resident 106. Staff did not provide assistance to Resident 106 with intake and prevent him from dropping food onto himself and the floor while trying to eat. CFR 483.10(a)(1) Resident Rights Previously Cited 02/27/2025 28 Pa. Code 211.12(d)(1)(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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. Based on facility policy review, observation, clinical record review, and resident and staff interview, it was determined that the facility failed to assess a resident's capability to self-administer medications for two of 23 sampled residents. (Residents 7, 12) Findings include: Review of the facility policy entitled, Self-Administration of Medications, last reviewed January 31, 2025, revealed that the facility was to assess and determine whether self-administration of medications was safe and clinically appropriate based on the resident's functionality and health condition. The policy also stated that the facility was to document in the resident's care plan whether the resident or facility staff was responsible for the storage of resident's medications and if the resident had been assessed as being responsible for the storage of his/her medications. The facility was to provide a secure compartment for storage of such medications in the resident's room. Clinical record review revealed that Resident 7 had diagnoses that included arthritis, fracture of the left femur, and muscle spasms. Observations on January 11, 2026, at 11:05 a.m., and on January 12, 2026, at 10:30 a.m., revealed that there was a bottle of Biofreeze (a topical pain reliever for relief of arthritis pain) and a tube of miconazole nitrate anti-fungal cream unsecured on the bedside tray table in Resident 7's room. In interviews at those times, Resident 7 stated that he self-administered the Biofreeze and the miconazole nitrate daily. There was no documentation to indicate that the facility had assessed Resident 7 for the ability to self-administer the Biofreeze and the miconazole nitrate. The medications were not secured in his room. Clinical record review revealed that Resident 12 had diagnoses that included congestive heart failure, chronic obstructive pulmonary disease, anxiety, depression and rash and other nonspecific skin eruptions. Observations on January 11, 2026, at 9:33 a.m., and on January 12, 2026, at 12:38 p.m., revealed that there was a tube of clobetasol cream 0.05% (a topical corticosteroid used to treat various inflammatory skin conditions) unsecured on the bedside tray table in Resident 12's room. In an interview on January 11, 2026, at 9:33 a.m., Resident 12 stated that she self-administered the cream as needed. There was no documentation to indicate that the facility had assessed Resident 12 for the ability to self-administer the clobetasol cream. The medications were not secured in her room. In an interview on January 13, 2025, at 11:36 a.m., the Director of Nursing confirmed that Residents 7 and 12 were not assessed to self-administer the medications as per the facility policy. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services.		

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law. Based on clinical record review, observation, and staff interview, it was determined that the facility failed to provide the physician ordered therapeutic diet for one of 23 sampled residents. (Resident 6) Findings include: Clinical record review revealed that Resident 6 had diagnoses that included heart disease, Parkinson's disease, and gastro-esophageal reflux disease (a chronic digestive disorder where stomach acid frequently flows back into the esophagus). A physician's order dated January 9, 2026, directed staff to provide a clear liquid diet for 48 hours. A dietary progress note dated January 12, 2026, stated that resident was to receive a clear liquid diet for all 3 meals on January 10 and 11, 2026. On January 11, 2026, at 1:00 p.m., the resident was observed eating lunch in his bed. The food items on his tray were mechanical soft vegetables and pureed roast beef. In an interview on January 13, 2026, at 11:10 a.m., the Registered Dietitian confirmed that the resident should have received a clear liquid diet for lunch on Sunday, January 11, 2026. 28 Pa. Code 201.14(a) Responsibility of licensee. 28 Pa. Code 201.18(b)(3) Management. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on facility policy review, clinical record review, observation, and staff interview, it was determined that the facility failed to implement enhanced barrier precautions and the use of personal protective equipment (PPE) to prevent the spread of infection for one of 23 sampled residents. (Resident 8) Findings include: Review of the facility policy entitled, Enhanced Barrier Precautions, last reviewed January 31, 2025, revealed that enhanced barrier precautions were to be used with any resident with a wound or indwelling device during encounters when contact is expected, including during wound care, the care of feeding and tracheostomy tubes, transferring residents and changing linens. Standard precautions such as hand hygiene always apply and precautions include the use of protective gowns and gloves during the high-risk activities. Clinical record review revealed that Resident 8 had diagnoses that included respiratory failure requiring a tracheostomy, history of a stroke, quadriplegia, dysphagia requiring a feeding tube, and neurogenic bladder requiring an indwelling catheter. Observations on January 11, 2026, at 12:18 p.m. revealed a licensed practical nurse (LPN 1) and a nurse aide (NA 1) entered Resident 8's room and did not perform standard hand hygiene or wear protective gowns and gloves prior to providing direct care to the resident. NA 1 was observed collecting his soiled briefs and linens, leaving the room, and not performing hand hygiene before retrieving clean linens. NA 1 then obtained a Hoyer lift, returned to Resident 8's room, and assisted transferring him out of bed into his reclining wheelchair. At 12:46 p.m., LPN 1 was observed in Resident 8's room carrying a syringe and a plastic beaker filled with a light-yellow liquid. LPN 1 left Resident 8's room with the beaker and syringe, entered another resident's room, then returned to Resident 8's room without performing hand hygiene or wearing a protective gown or gloves. On January 12, 2026, at 1:30 p.m., the Administrator confirmed that staff did not adhere to the facility infection control policy. 28 Pa. Code 211.10(d) Resident care policies. 28 Pa. Code 211.12(d)(1)(5) Nursing services.		

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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 notify the resident and the resident's representative(s) of transfer(s), including the reasons for the moves and Ombudsman information, in writing upon transfer from the facility for three of three sampled residents who were transferred to the hospital. (Residents 7, 8, 45) Findings include: Clinical record review revealed that Resident 7 was transferred to the hospital on September 23, 2025, after a change in condition. There was no documented evidence that the resident and the resident's representative were provided with a written transfer notice. Clinical record review revealed that Resident 8 was transferred to the hospital on November 13, 2025, after a change in condition. There was no documented evidence that the resident and the resident's representative were provided with a written transfer notice. Clinical record review revealed that Resident 45 was transferred to the hospital on September 30, November 9, and December 23, 2025, after changes in condition. There was no documented evidence that the resident and the resident's representative were provided with a written transfer notice. In an interview on January 13, 2025, at 11:40 a.m., the Administrator confirmed that the residents and resident representatives were not given written notices regarding the identified resident transfers. 28 Pa. Code 201.14(a) Responsibility of licensee. 28 Pa. Code 201.18(b)(3) Management.		