STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395499	A. Building B. Wing	04/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tremont Health & Rehabilitation Center	44 Donaldson Road Tremont, PA 17981

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, it was determined that the facility failed to provide a safe, clean, and comfortable environment on two of three nursing units. (Nursing Units B, C and E)Findings include: Observations on April 7, 2026, from 10:30 a.m. to April 9, 2026, at 1:00 p.m., revealed the following: The privacy curtain in room [ROOM NUMBER] was stained. In rooms 302, 304, 306, and 312 the air conditioning units were dirty and had a thick layer of dust. The linen closet floors were dusty and dirty under the last shelf. On Unit B, two mechanical lifts and one sit to stand lift were observed and had thick hair and debris wrapped around the wheels. On Unit B, a beverage cart had thick hair and debris wrapped around the wheels two days in a row. The beverage carts were brought to the unit with beverages prior to the meal delivery carts and taken back to the kitchen after the meal. In the nourishment room on Unit B, inside the microwave there was a large amount of dried orange liquid staining on the turntable dish with light discolored spatter residue on the walls. In an interview on April 9, 2026, at 10:41 a.m., a nurse aide (NA 2) stated that the microwave is used to heat up resident food. In the nourishment room on Unit C, there was black dust on the top of microwave and food splashed throughout the sides of the microwave. In the hallways of Units C and E, there was a black substance and sticky residue on the floors. A black substance and sticky residue were observed on the floors in rooms 708, 803, 809 and in the E wing nutrition room. The valances on the windows next to the exits in C and E wings were dirty with cobwebs and dust. Observation on Unit B, on April 8, 2026, at various times from 10:00 a.m. to 12:52 p.m., revealed in the women's shower room there was a comb on the floor in the back corner next to the tub. There was a roll of toilet paper strewn on the floor next to the left side of the tub. The tub contained three hangers, 2 disposable razors, a bag containing two briefs, two cans of shaving cream, one bottle of body wash and a half full spray bottle of yellow/orange liquid. The rolling shower table had a pillow on it. Observation of the men's shower room revealed there was a musty odor. There was a set of partitioned clothing bins containing soiled personal linens and trash. The showerhead had a constant drip with water pooled on the floor. There was dirt and debris in the bottom of the tub. 28 Pa. Code 201.14(a) Responsibility of licensee. 28 Pa. Code 201.18(b)(1) Management.

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and observation, it was determined that the facility failed to provide care and services to one of 35 sampled residents in a manner that maintained each resident's dignity. (Resident 23)Findings include: Clinical record review revealed that Resident 23 had diagnoses that included bipolar disorder and depression. The Minimum Data Set assessment dated [DATE], indicated that the resident was cognitively impaired and required assistance with self-care including eating. A review of the care plan identified that the resident was at nutritional risk and required restorative training and skill practice for eating and swallowing. There was an intervention for staff to provide her with assistance during meals. Observation on April 7, 2026, at 12:10 p.m. through 12:45 p.m., revealed that staff had delivered Resident 23's lunch meal to her in the dining room. The resident received puree texture food on a regular plate that was on top of a base. The resident attempted to eat the pureed meal with a spoon and was having difficulty getting the food on the spoon. As the resident attempted to scoop the food with the spoon, it was pushed off the plate and onto the table. At no time during the observation did staff offer assistance to Resident 23 to ensure dignity was maintained with dining. 28 Pa. Code 201.29(a) Resident rights.

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, clinical record review, and facility documentation review, it was determined that the facility failed to report an alleged violation of verbal abuse for one of 36 sampled residents. (Resident 140)Findings include:Review of the facility policy entitled, Pennsylvania Resident Abuse, last reviewed March 24, 2026, defined verbal abuse as the use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents, regardless of their age or ability to comprehend. Review of the policy further revealed that the Administrator or Abuse Coordinator would notify the applicable local and state authorities of abuse allegations.Clinical record review revealed that Resident 140 had diagnoses that included major depressive disorder and diabetes. The Minimum Data Set assessment dated [DATE], indicated that the resident had no cognitive impairment. On March 18, 2026, a nurse noted that Resident 140 notified staff that someone had left mean notes in his room and the resident needed to be consoled by staff. Review of facility documentation dated March 18, 2026, revealed that a sticky note was left in the resident's room that included a disparaging and derogatory term.There was no documented evidence that the facility identified the incident as verbal abuse and reported the incident to the appropriate state and local agencies as per facility policy.28 Pa. Code 201.18(b)(1)(e)(1) Management.28 Pa. Code 201.29(a) Resident rights.

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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 interview, it was determined that the facility failed to complete an accurate Minimum Data Set (MDS) assessment for three of 35 sampled residents. (Residents 5, 12, 51)Findings include: Clinical record review revealed that Resident 5 had diagnoses that included muscle contractures and cerebral infarction (stroke). Review of an occupational therapy Discharge summary dated [DATE], revealed Resident 5 was to wear bilateral (both sides) elbow splints. Review of Resident 5's care plan revealed he was on a Restorative Nursing Program (RNP) with an intervention for staff to apply bilateral elbow splints. Review of Resident 5's Minimum Data Set (MDS) assessment dated [DATE], did not indicate that Resident 5 was on a RNP for splint assistance. Clinical record review revealed that Resident 12 had diagnoses that included neurogenic bladder. A physician's order dated April 3, 2024, directed staff to care for Resident 12's bladder catheter. Review of the MDS assessment dated [DATE], did not indicate that Resident 12 had a bladder catheter inserted. Clinical record review revealed that Resident 51 had diagnoses that included respiratory failure. A physician's order dated March 20, 2026, directed staff to administer supplemental oxygen at 3 liters per minute to the resident. Review of the MDS assessment dated [DATE], did not indicate that Resident 12 was receiving oxygen. In an interview on April 10, 2026 at 9:42 a.m., the Administrator confirmed that Resident 12's MDS was inaccurate and should have included the use of a bladder catheter and Resident 51's MDS was inaccurate and should have included the use of continuous oxygen. In an interview on April 10, 2026, at 11:02 a.m., the Director of Nursing confirmed Resident 5's MDS was inaccurate and that it should have included the RNP and the use of the splint.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and staff interview, it was determined that the facility failed to develop a comprehensive care plan that addressed individual resident needs as identified in the comprehensive assessment for one of 35 sampled residents. (Resident 14)Findings include: Clinical record review revealed that Resident 14 had a diagnosis of depression. Review of the Minimum Data Set assessment dated [DATE], identified that the resident had symptoms of depression. According to the Care Area Assessment summary dated January 12, 2026, the facility identified that depression was a problem for the resident and should have been included in the comprehensive care plan. Review of the care plan revealed that the facility did not develop interventions to address the care area of depression. In an interview conducted on April 10, 2026, at 11:25 a.m., the Director of Nursing confirmed that there was no care plan developed with interventions to address Resident 14's depression. 28 Pa. Code 211.12(d)(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 observation and staff interview, it was determined that the facility failed to ensure that the environment remained free of accident hazards in one of six shower rooms. (B unit women's shower room)Findings include: Observations of B unit Women's Shower room on April 8, 2026, at 12:55 p.m., revealed that the entry door was not locked and was observed to be used as a common bathroom for toileting. The tub was observed to contain two disposable razors, two cans of shaving cream, one bottle of body wash and a spray bottle that was half full of a yellow/orange color liquid. In an interview on April 8, 2026, at 1:42 p.m., the Director of Nursing stated that the spray bottle contained a chemical cleaner and that there were three ambulatory residents that were cognitively impaired who could have accessed the potentially hazardous materials. 28 Pa. Code 211.12(d)(5) Nursing services.

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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, staff interview, and review of facility policy it was determined that the facility failed to store respiratory equipment appropriately for one of three sampled residents who received oxygen therapy. (Resident 12)Findings include: Review of the facility policy entitled, Oxygen Administration, dated March 24, 2026, revealed that oxygen cannulas (a tube with two prongs where each prong is inserted into each nostril of the nose) and masks were to be changed weekly. When oxygen tubing was not in use it was to be kept in a plastic bag. Staff were to place a new bag on the side of the concentrator or portable oxygen tank weekly to hold the tubing. Clinical record review revealed that Resident 12 had diagnoses that included chronic congestive heart failure and dependence on supplemental oxygen. On December 10, 2025, the physician ordered that staff administer oxygen therapy via nasal cannula at a rate of three liters per minute at bedtime. Review of the Minimum Data Set assessment for March 17, 2026, revealed that the resident was alert and oriented. Observations on April 8, 2026, at 9:07 a.m., and 12:30 p.m., revealed the tubing was attached to the oxygen concentrator in the resident's room. The oxygen was not in use and the nasal cannula was draped over the top of the oxygen concentrator and was not stored in the attached storage bag. During an interview with the resident on April 8, 2026, at 10:24 a.m., the resident stated that staff assist him daily with placing the nasal cannula on at bedtime for supplemental oxygen and that they remove the nasal cannula in the morning and store it for him. During an interview on April 10, 2026, at 9:45 a.m., the Director of Nursing confirmed that the oxygen cannula should have been placed in the storage bag when not in use. 28 Pa. Code 211.12 (d)(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 a resident's representative of a resident's appeal rights upon transfer to the hospital or notify the Ombudsman in writing of a resident's discharge from the facility for two of seven sampled residents who were transferred to the hospital or discharged . (Residents 12 and 171) Findings include: Clinical record review revealed that Resident 12 was transferred to the hospital on December 4, 2025, after a change in condition. There was no documented evidence that the resident's responsible party was provided information regarding appeal rights. In an interview on April 10, 2026, at 9:52 a.m., the Administrator confirmed that Resident 12's representative was not provided with a transfer notice that included the required information. Clinical record review revealed that Resident 171 was discharged from the facility on March 3, 2026. There was no documented evidence that the Ombudsman was notified of the discharge. In an interview on April 10, 2026, at 12:50 p.m., Employee 3 confirmed that the Ombudsman was not notified of Resident 171's discharge from the facility.