STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395571	A. Building B. Wing	07/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Muncy Place	215 East Water Street Muncy, PA 17756

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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 - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation and staff interview, it was determined that the facility failed to ensure resident dignity during dining for two of two residents reviewed (Residents 94 and 100).Findings include: Observation on July 22, 2025, at 12:21 PM revealed Employee 1, nurse aide, feeding both Resident 94 and Resident 100 their lunch meals. Employee 1 stood between the two residents who were seated next to the dining table while she fed them. During this same time, Employee 1 would leave the table and grab other plates to serve other residents in an adjacent dining room. Observation on July 22, 2025, at 12:26 PM revealed that Employee 1 left Resident 94 and Resident 100, and Employee 2, nurse aide, arrived and finished feeding both Resident 94 and Resident 100. Employee 2 also stood between both Resident 94 and Resident 100 to finish feeding them. Observation on July 23, 2025, at 12:32 PM revealed that the facility served Resident 94 and Resident 100 their lunch meals. Employee 3, nurse aide, began feeding Resident 100 his meal standing up at 12:35 PM. Employee 3 continued feeing Resident 100 for 30 minutes while she stood the entire time. Employee 3 then left with Resident 100 out of the dining area and did not return. There were no observations of nursing staff attempting to feed Resident 94 until 1:00 PM, at which time he was asleep. The above findings were reviewed during an interview with the Administrator and the Director of Nursing on July 24, 2025, at 2:18 PM. 28 Pa. Code 201.29(j) Resident rights

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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on clinical record review and staff interview it was determined that the facility failed to ensure a resident's medication regime was free from potentially unnecessary psychotropic medication for one of five residents reviewed for medication regimen review (Resident 85). Findings include: Clinical record review for Resident 85 revealed an active physician's order dated July 8, 2025, for staff to administer the antianxiety medication, Alprazolam, 1 mg (milligram) as needed (PRN) every eight hours with a stop date of January 3, 2026, (180 days from the order date). Active physician orders for Resident 85 also included instructions for staff to administer 0.5 mg of Alprazolam three times daily (order date November 26, 2024).Per the medication resource Drugs.com, the usual maximum adult dose for anxiety is 4 mg per day. The lowest possible effective dose should be administered and the need for continued treatment reassessed frequently. If administered as often as the active physician orders permitted, Resident 85 could receive 4.5 mg of Alprazolam per day, which exceeds the usual maximum adult dose.Review of Resident 85's medication administration record (MAR, electronic documentation of the administration of medications) dated May 2025, revealed that Resident 85 received the PRN dose of the Alprazolam medication on 16 occasions on the following dates and times:May 1, 2025, at 10:27 AMMay 8, 2025, at 11:00 AMMay 9, 2025, at 10:35 AMMay 12, 2025, at 10:00 AMMay 15, 2025, at 11:49 AMMay 17, 2025, at 12:00 PMMay 18, 2025, at 11:00 AMMay 20, 2025, at 11:00 AMMay 21, 2025, at 10:25 AMMay 23, 2025, at 10:00 AMMay 25, 2025, at 4:04 PMMay 26, 2025, at 4:01 PMMay 27, 2025, at 11:00 AMMay 28, 2025, at 11:04 AMMay 29, 2025, at 10:30 AMMay 31, 2025, at 3:38 PMReview of Resident 85's MAR dated June 2025, revealed that Resident 85 received the PRN dose of the Alprazolam medication on seven occasions on the following dates and times:June 1, 2025, at 10:20 AMJune 4, 2025, at 11:05 AMJune 5, 2025, at 10:00 AMJune 9, 2025, at 11:35 AMJune 12, 2025, at 11:08 AMJune 18, 2025, at 10:00 AMJune 20, 2025, at 11:04 AMReview of Resident 85's MAR dated July 2025, revealed that Resident 85 received the PRN dose of the Alprazolam medication on four occasions from July 1 through 28, 2025, on the following dates and times:July 9, 2025, at 12:00 PMJuly 13, 2025, at 11:00 AMJuly 14, 2025, at 11:00 AMJuly 17, 2025, at 11:01 AMResident 85's documented use of the PRN Alprazolam medication indicated that she did not require the PRN dose daily; nor did she exceed more than one dose in one day. Interview with the Director of Nursing, the Nursing Home Administrator, Employee 4 (assistant director of nursing), and Employee 5 (assistant nursing home administrator), on July 25, 2025, at 12:00 PM confirmed the above findings for Resident 85.The evidence reviewed also indicated that staff consistently administered the PRN Alprazolam between the hours of 10:00 AM and 12:00 PM on 24 of the 27 occasions.Review of Resident 85's plans of care did not provide evidence that the facility identified the pattern of Resident 85's PRN Alprazolam use; or implemented an individualized intervention to address Resident 85's need for PRN antianxiety medication at a consistent time of day. Due to the above documented frequency of the administration of the PRN dose of Alprazolam, there was insufficient evidence that Resident 85 required the Alprazolam dose to exceed the recommended daily maximum, or that the stop date of 180 days met the regulatory requirement for physician review (at 14 days).28 Pa. Code 211. 12(d)(1)(3)(5) Nursing services

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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 related to anticoagulant use for one of five residents selected for medication regimen review (Resident 85). Findings include: Clinical record review for Resident 85 revealed an active physician's order dated January 2, 2025, for staff to administer the anticoagulant medication Eliquis (anticoagulants are a family of medications that stop your blood from clotting too easily; they can break down existing clots or prevent clots from forming in the first place) 2.5 mg (milligrams) two times daily. Review of an annual MDS (Minimum Data Set, an assessment tool completed at specific intervals to determine resident care needs) dated February 2, 2025, assessed Resident 85 as taking an anticoagulant medication. A quarterly MDS assessment dated [DATE], assessed Resident 85 as taking an anticoagulant medication. Review of plans of care developed by the facility to identify and address Resident 85's medical needs did not include a plan of care that noted her use of an anticoagulant medication. The plans of care did not address pertinent associated risks and the prevention of potential complications from the use of an anticoagulant (e.g., bleeding and bruising). Interview with the Director of Nursing, the Nursing Home Administrator, Employee 4 (assistant director of nursing), and Employee 5 (assistant nursing home administrator), on July 25, 2025, at 12:00 PM confirmed the above findings for Resident 85. 28 Pa. Code 211.12(d)(1)(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 clinical record review and staff interview, it was determined that the facility failed to provide the highest practicable care regarding physician ordered medication parameters for one of 21 residents reviewed (Resident 1). Findings include: Clinical record review for Resident 1 revealed a diagnosis list that included hypertension (high blood pressure). A review of the current physician orders for Resident 1 revealed an order dated May 15, 2025, for Metoprolol Tartrate (a medication that is used to treat high blood pressure and/or heartrate) 25 milligrams (mg) give one tablet by gastrostomy tube (a medical tube inserted through the abdomen into the stomach to provide feeding, hydration, and/or medications) every eight hours. The order indicated a blood pressure and/or pulse hold: pulse less than 60; systolic blood pressure (SBP, the top number of a blood pressure reading where the heart contracts) less than 100. A review of the Medication Administration Record (MAR) from May, June, and July 2025, for Resident 1 revealed that the Metoprolol was marked as administered outside of the physician specified parameters for the following dates: May 27 during the midnight administration; the blood pressure was documented as 92/63.June 15 during the midnight administration; the blood pressure was documented as 93/63.June 17 during the midnight administration; the blood pressure was documented as 99/72. July 8, during the midnight administration; the blood pressure was documented as 95/63.July 10, during the midnight administration; the blood pressure was documented as 90/59.July 10, during the 8:00 AM administration; the blood pressure was documented as 94/66. There was no documentation for Resident 1 to indicate a rationale for why the medication was administered outside of the specific stated parameters. The facility provided nursing shift report sheets (sheets used by nursing staff to keep track of important resident information that are not part of the clinical record) with attached dates written on post-it notes of May 27, June 15, June 17, July 8, and July 10 that the facility indicated the doses of Metoprolol were held those dates; however, Resident 1's medication administration record documentation does not reflect that the doses were held. The above information for Resident 1 was reviewed in a meeting with the Nursing Home Administrator and Director of Nursing on July 23, 2025, at 2:15 PM. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. Based on clinical record review, observation, and family and staff interview, it was determined that the facility failed to implement physician ordered interventions for a resident with limited range of motion for one of nine residents reviewed for range of motion concerns (Resident 85). Findings include: Clinical record review for Resident 85 revealed an active physician's order dated June 4, 2024, that instructed staff to ensure Resident 85 wore a left palm guard with digit separators (splint worn on the hand with cushioning to split the fingers and protect the palm) in the morning for four hours and in the evening for four hours with skin checks every two hours. Review of a plan of care developed by the facility for contracture prevention for Resident 85 revealed a goal that Resident 85 would wear the left palm guard/digit separator for four hours in the morning and four hours in the evening. Interventions included in the plan of care indicated that nursing staff would don (apply) and doff (remove) the splint as scheduled for further contracture prevention. Observation of Resident 85 on July 22, 2025, at 12:14 PM in the common dining area on the nursing unit revealed no splint to her left hand. The fingers of Resident 85's bilateral hands were bent; and it appeared that Resident 85 used her knuckles to grasp beverage cups during her lunch meal. Interview with Resident 85's husband on July 22, 2025, at 2:53 PM confirmed that Resident 85's hands have arthritic changes (stiffness, swelling, and limited mobility of joints). Resident 85's husband stated, you cannot straighten them. Resident 85's husband stated that it depends on what staff are working if Resident 85 has her hand splint on or not. Resident 85's husband stated that the splint use is inconsistent. Observation of Resident 85 on July 23, 2025, at 1:05 PM revealed two nurse aides transferred her back to bed. Resident 85 did not have a splint on her left hand. Interview with Employee 10 (one of the two nurse aides caring for Resident 85) on July 23, 2025, at 1:11 PM revealed that she believed staff from the overnight shift applied Resident 85's splint. Employee 10 stated that Resident 85 wears the splint in the morning from 6:00 AM to 8:00 AM. Employee 10 referred to the electronic kiosk in the hallway that contained resident care instructions and reported that the only instructions for the nurse aides were to, don and doff splint as scheduled. Employee 10 stated that she removed a splint from Resident 85 at 8:00 AM that morning, and she was not sure when Resident 85 should wear it again during her day. Review of nurse aide documentation of the application of Resident 85's hand splint revealed that only day and evening shift staff document the implementation of the device (not overnight shift). No staff initialed the implementation of the hand splint intervention for Resident 85 on either the day or evening shift on July 23, 2025. Observation of Resident 85 in the nursing unit dining room on July 25, 2025, at 9:18 AM revealed she was using her bilateral hands that were formed into fists to drink from a cup. Resident 85's fingers were contracted (bent). Resident 85 was not wearing a hand splint. Observation of Resident 85 on July 25, 2025, at 11:38 AM revealed she was in her room without a hand splint on her left hand. Interview with Employee 11 (nurse aide) on July 25, 2025, at 11:41 AM revealed that she did not know the schedule to follow for Resident 85's hand splint. Employee 11 confirmed that she was assigned to Resident 85's care on this date. Employee 11 located a hand splint device on Resident 85's overbed table and Resident 85 permitted Employee 11 to apply the device to her left hand. The surveyor reviewed the above concerns regarding Resident 85's hand splint use during an interview with the Director of Nursing, the Nursing Home Administrator, Employee 4 (assistant director of nursing), and Employee 5 (assistant nursing home administrator), on July 25, 2025, at 12:00 PM. 483.25(c)(1)-(3) Increase/prevent Decrease in ROM/mobilityPreviously cited deficiency 8/16/2024 28 Pa. Code 211.12(d)(1)(5) Nursing services

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on a review of select facility policies and procedures, clinical record review, observation, and staff interview, it was determined that the facility failed to provide appropriate treatment and services for a resident who is fed by enteral means to prevent potential complications for one of three residents reviewed for tube feeding concerns (Resident 5). Findings include: The surveyor requested the facility policies and procedures related to bolus feeding (the administration of a limited volume of liquid nutrition formula over a brief period of time) via a gastrostomy tube (G-tube, a tube that is placed directly into the stomach through an abdominal wall incision for administration of food, fluids, and medications; also known as a PEG tube) during an interview with the Nursing Home Administrator, Director of Nursing, Employee 4 (assistant director of nursing), and Employee 5 (assistant nursing home administrator), on July 25, 2025, at 12:00 PM; and again, during an interview with Employee 5 on July 25, 2025, at 1:00 PM. The facility was only able to provide a policy entitled, Enteral Tube Medication Administration, last reviewed without changes on June 17, 2025, that instructed staff to verify tube placement per facility protocol before administering medications. The policy instructed staff to allow medication to flow down the tube via gravity; give gentle boosts with the plunger (one inch down) if the medication will not flow by gravity, repeat, if necessary, do not push medications through the tube. The facility was unable to provide the facility protocol used to verify tube placement during the onsite survey. Interview with Resident 5 on July 22, 2025, at 1:01 PM revealed that she receives liquid nutrition every four hours through a tube in her abdomen (PEG tube); that she is not allowed food consumption through her mouth. Resident 5 stated that she had surgery to place this abdominal tube three weeks ago. Nursing documentation dated June 19, 2025, at 1:01 PM revealed that the hospital staff gave a report of Resident 5's condition to the writer that included that Resident 5 had a PEG tube placed due to esophageal dysmotility (when the esophagus does not move food and liquid from the mouth to the stomach as it should). Clinical record review for Resident 5 revealed active physician orders dated June 19, 2025, for the following care needs for Resident 5: Nothing by mouth (NPO)One carton of Nutren 2.0 (liquid nutrition) three times a dayCleanse and apply a dressing to a G-tube site daily and as neededTube Feeding - Check placement 3 (three) times dailyTube Feeding - Check residual 3 times dailyTube Feeding - Check placement PRN (as needed)Tube Feeding - Check residual PRN Observation of Resident 5's bolus G-tube feeding on July 25, 2025, at 8:50 AM with Employee 12 (registered nurse) revealed Employee 12 filled a syringe with 50 milliliters of water and flushed Resident 5's tube by pressing the plunger of the syringe. Employee 12 did not allow gravity to instill the water into Resident 5's stomach. Employee 12 did not attempt any intervention to verify the correct placement of Resident 5's G-tube before completing the flush. Employee 12 did not check for any residual feeding in Resident 12's stomach before completing the flush. Employee 12 repeated the process of filling the syringe with Nutren 2.0 liquid nutrition and administering the Nutren 2.0 via Resident 5's G-tube by pushing the plunger four times until the entire 8.45 fluid ounces of liquid nutrition was consumed. Employee 12 did not attempt to allow the liquid nutrition to flow into Resident 5's stomach via gravity. Continued observation of the G-tube feeding on July 25, 2025, at 9:02 AM revealed Employee 12 flushed Resident 5's G-tube with 100 milliliters of water by pushing the plunger of the syringe (not via gravity). Following the completion of the G-tube feeding on July 25, 2025, at 9:04 AM Employee 12 rinsed the used syringe in Resident 5's bathroom, removed her gloves, obtained dressings and saline from Resident 5's in-room cabinet, and donned new gloves without performing hand hygiene (e.g., alcohol hand sanitizer or hand washing with soap and water). Employee 12, then, cleansed Resident 5's G-tube insertion site and applied a new gauze dressing around Resident 5's G-tube. Interview with Employee 12 on July 25, 2025, at 9:12 AM confirmed that she did not complete any G-tube flushes or feedings via a gravity method. Employee 12 denied completing any interventions to confirm the appropriate placement of Resident 5's G-tube. Employee 12 indicated that there were numerical markings visible on Resident 5's G-tube; however, she did not know what number would indicate a correct insertion depth for Resident 5. Employee 12 confirmed that she did not assess for any residual feeding (e.g. aspirate stomach contents) before completing the task. Employee 12 also confirmed that she did not wash her hands or utilize hand sanitizer after removing soiled gloves and donning new gloves. Interview with Employee 5 on July 25, 2025, at 1:00 PM confirmed that the documentation of Employee 12's competency related to G-tube care reviewed a process of care utilizing a gravity method. The procedural steps in the competency did not include using a plunger method to complete the entire process of instillation via a G-tube. 28 Pa. Code 211.10(a)(c)(d) Resident care policies 28 Pa

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation and staff interview, it was determined that the facility failed to store food items in a safe and sanitary manner and maintain the environment in a safe and sanitary condition in the facility's main kitchen and second floor kitchenette.Findings include: Observation of the facility's main kitchen with Employee 6, Dietary Manager, on July 22, 2025, at 8:45 AM revealed the following: A walk-in cooler contained the following: A bag of lunch meat with no dates on it. A container of asiago cheese with a use by date of July 13, 2025. A container of provolone cheese with a use by date of July 5, 2025. A large bag of lettuce opened to the ambient air with a use by date of July 19, 2025. A container labeled, vegetable fresh prep, with a use by date of July 13, 2025.Cooked bacon with a use by date of July 13, 2025. A container of chicken salad with a use by date of July 19, 2025.Feta cheese with a use by date of July 19, 2025. A second walk-in cooler had a damaged single serve milk carton that was leaking onto the adjacent cartons and surrounding area. A hospitality cart in the dry storage area had a snack bag of expired pretzels. A storage rack holding various adaptive equipment had a container of clear, plastic cups with handles. Multiple cups were noted to have a build-up of moisture. Employee 6 was unable to state how long the cups were wet. The dishwashing area contained the following: A black colored, plastic, corner floor shelf that held various housekeeping items with an accumulation of debris underneath it. The debris included food items, a single-use butter container, and a drinking straw. The corner of the dishwashing room where a fan was attached had a significant accumulation of dried splash stains on the walls and ceiling. The fan had a build-up of dust on the protective cover and fan blades. The floor, adjacent to a floor drain under the ice machine, contained various debris, including a plastic cup, and a broken piece of a red colored plate. Observation of the second floor kitchenette on July 23, 2025, at 11:00 AM revealed the resident refrigerator contained a sandwich with no dates or label on it. The above findings were reviewed with the Nursing Home Administrator and Director of Nursing on July 23, 2025, at 2:00 PM. 28 Pa. Code 201.14 (a) Responsibility of Licensee

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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 review of select facility policies and procedures, observation, clinical record review, and staff interview, it was determined that the facility failed to implement contact precautions for one of two residents reviewed for isolation concerns (Resident 4), and implement proper hand hygiene practices consistent with accepted standards of practice for two of 21 residents (Residents 5 and 9). Findings include:Review of the facility policy entitled, Hand Hygiene, dated July 18, 2025, revealed that hand hygiene must be performed prior to donning gloves when gloves are being worn for interaction with a patient and/or patient zone. Hand hygiene must be performed after removing gloves when gloves are being worn for interaction with a patient and/or patient zone and patient surroundings. Remove gloves, clean hands, and don a fresh pair of gloves when caring for a patient that requires moving from a dirty site to a clean site. Clinical record review for Resident 9 revealed nursing documentation dated July 21, 2025, at 2:11 PM that Resident 9 had increasing edema (swelling) in both her arms over the weekend. The nurse noted four open areas on Resident 9's arms, and treatment included an oil emulsion dressing (a non-adherent gauze mesh that is impregnated with an oil-based substance, typically white petrolatum or a similar emollient, that allows the dressing to create a protective barrier over the wound, minimizing trauma during dressing changes, and ensuring that the dressing does not stick to the wound surface), gauze, and kerlix wrap (rolled stretchable gauze) daily and as needed. Observation of wound care for Resident 9 with Employee 12 (registered nurse) on July 25, 2025, at 8:27 AM revealed Employee 12 removed the soiled kerlix wrapping, gauze, and oil emulsion dressings from Resident 9's right arm. Employee 12 removed her gloves and donned new gloves without performing hand hygiene (e. g., alcohol hand sanitizer or hand washing with soap and water). Employee 12 used saline-soaked gauze to cleanse two sites on Resident 9's right mid forearm. Employee 12 removed her gloves to open the packaging of the oil emulsion dressings and donned new gloves without performing hand hygiene. Employee 12 applied an oil emulsion dressing over each wound site on Resident 9's right arm, applied sterile gauze, and wrapped Resident 9's right forearm with kerlix dressing. Employee 12 removed her gloves and donned new gloves without performing hand hygiene. Continued observation of Resident 9's wound care on July 25, 2025, at 8:38 AM revealed Employee 12 removed the soiled kerlix wrapping, gauze, and oil emulsion dressings from Resident 9's left arm. Employee 12 removed her gloves and donned new gloves without performing hand hygiene. Employee 12 cleansed two sites on Resident 9's left forearm with saline-soaked gauze, applied oil emulsion dressings and gauze over the two wound sites, and wrapped Resident 9's left arm with kerlix dressing. Employee 12 removed her gloves before documenting the date on Resident 9's dressing. Employee 12 donned new gloves without performing hand hygiene to clean Resident 9's overbed table and remove the garbage from Resident 9's room. Interview with Resident 5 on July 22, 2025, at 1:01 PM revealed that she receives liquid nutrition every four hours through a tube in her abdomen (gastrostomy tube or G-tube, a tube that is placed directly into the stomach through an abdominal wall incision for administration of food, fluids, and medications; also known as a PEG tube); that she is not allowed food consumption through her mouth. Resident 5 stated that she had surgery to place this abdominal tube three weeks ago. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Nursing documentation dated June 19, 2025, at 1:01 PM revealed that the hospital staff gave a report of Resident 5's condition to the writer that included that Resident 5 had a PEG tube placed due to esophageal dysmotility (when the esophagus does not move food and liquid from the mouth to the stomach as it should). Observation of Resident 5's bolus G-tube feeding (the administration of a limited volume of liquid nutrition formula over a brief period of time) via a PEG tube with Employee 12 on July 25, 2025, at 8:50 AM revealed Employee 12 used gloved hands to flush water and instill liquid nutrition into Resident 5's stomach until 9:04 AM when Employee 12 rinsed the syringe used for the procedure in Resident 5's bathroom sink. Employee 12 removed her gloves, obtained dressings and saline from Resident 5's in-room cabinet, and donned new gloves without performing hand hygiene. Employee 12 then cleansed Resident 5's G-tube insertion site and applied a new gauze dressing around Resident 5's G-tube. Interview with Employee 12 on July 25, 2025, at 9:12 AM confirmed that she did not wash her hands or utilize hand sanitizer after removing soiled gloves and donning new gloves during the care observed for Residents 5 and 9. Review of the facility policy titled, “Transmission Based Precautions in Long Term Care,” last reviewed without changes on June 17, 2025, revealed that “contact precautions are intended to prevent transmission of pathogens that are spread by direct or indirect contact with the resident or environment and require the use of appropriate personal protective equipment (PPE), including gowns and gloves before or upon entering (i.e. before making contact with the resident or resident’s environment) the room or cubicle.“ Review of the facility policy titled, Patient and Exam Room Cleaning Procedures, last reviewed without changes on June 17, 2025, revealed a section titled, Before Entering the Room, which instructed staff to look for isolation signs that indicate the need for personal protective equipment and special precautions. Wear required personal protective equipment. Clinical record review for Resident 4 revealed a diagnosis list that included a history of urinary tract infections, hydronephrosis (a swelling of the kidney caused by a build-up of urine), and calculus of the kidney (kidney stone). Current physician orders for Resident 4 revealed orders for an indwelling urinary foley catheter (medical tubing inserted into the bladder to drain urine) and associated care. Clinical record review for Resident 4 revealed a progress note dated July 21, 2025, at 11:25 AM that noted the resident was started on Cipro (an antibiotic medication to help fight bacteria in the body) for a urinary tract infection; asymptomatic urine was tested for pre-operative testing. Lab documentation revealed a urinalysis and associated culture for Resident 4 dated July 16, 2025, that noted various bacteria in the urine: Escherichia coli ESBL, enterococcus faecalis, pseudomonas aeruginosa, and mixed flora. Observation of Resident 4’s room on July 22, 2025, at 10:30 AM revealed a yellow sign on the doorframe outside of the room that indicated the resident was on contact precautions. The sign noted all staff and visitors must follow these precautions, which included hand hygiene, gown, and gloves. Employee 7, housekeeping staff, was observed entering the room with no gown. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395571	A. Building B. Wing	07/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Muncy Place	215 East Water Street Muncy, PA 17756

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	Continued observation of Resident 4’s room on July 22, 2025, at 10:36 AM revealed Employee 7 proceeded to clean the room and was wiping various surfaces that included the bedside table and wall vent. The employee was then observed sweeping the floor of the room. Employee 7 did not have on a gown as indicated by the isolation sign. Observation of Employee 7 on July 22, 2025, at 10:51 AM revealed the employee left the room with gloves on and entered the hallway. She proceeded to throw something away in the housekeeping cart positioned outside of Resident 4’s room. Employee 7 then returned to the room to finish cleaning. An interview with Employee 7 on July 22, 2025, at 11:00 AM revealed that the employee may have missed seeing the yellow contact isolation sign and should have worn a gown in addition to the gloves to clean Resident 4’s room. An interview with Employee 8, licensed practical nurse, on July 22, 2025, at 2:56 PM confirmed that Resident 4 is on contact isolation due to antibiotics and an upcoming urology appointment procedure. Further review of Resident 4’s clinical record revealed a care plan for enhanced barrier precautions (EBP, gown and glove use during direct care used in nursing homes to prevent the spread of multi-drug resistant organisms which are bacteria that are resistant to some antibiotics). The clinical record did not reveal an existing order or care plan for contact isolation. The new care that was added by the facility on July 23, 2025 (after discussion with the surveyor), noted an infection requiring precautions with the site documented as “urine organism ESBL.” The care plan noted the resident's goal of, “…will comply with contact precautions.” The above information for Resident 4 was reviewed in a meeting with the Nursing Home Administrator and Director of Nursing on July 23, 2025, at 2:49 PM. The facility reported that the expectation would be that the cleaning staff utilize a gown and gloves to clean the isolation room. An interview with Employee 9, registered nurse, on July 24, 2025, at 10:05 AM confirmed that Resident 4 is on contact isolation due to ESBL in the urine and pre-operative precautions. 483.80(a)(1)(2)(4)(e)(f) Infection Prevention and ControlPreviously cited deficiency 8/16/24 28 Pa. Code 211.12(d)(1)(5) Nursing services 28 Pa. Code 201.18(b)(1) Management 28 Pa. Code 211.10(d) Resident care policies