STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395699	A. Building B. Wing	08/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sweden Valley Manor	1028 East Second Street Coudersport, PA 16915

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 0571 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Limit the charges against residents' personal funds for items or services for which payment is made under Medicare or Medicaid. Based on resident and staff interview, clinical record review, and review of a resident fund account facility documents, it was determined that the facility imposed a charge against a resident's personal funds for a service which payment is made under Medicaid, for one two residents reviewed (Resident 60).Findings include: Interview with Resident 60 on August 6, 2025, at 9:59 AM revealed that she has new eyeglasses ready to be picked up, but she has to pay for them first. She indicated that she could see out of the glasses that she has but sometimes it is blurry. She said that she would not have her new glasses paid off until October 2025, because she has to pay for them with her monthly allowance of $45.00 dollars. She said since she has to pay for the glasses, she would not receive any personal spending money until October 2025, when her glasses were paid off. Clinical record review for Resident 60 revealed that her current insurance is a Medicaid plan. Further clinical record review revealed that Resident 60 was sent out to a local eye doctor for an acute problem on February 11, 2025. A consult provided to the surveyor from that visit revealed that Resident 60 needed new glasses to improve her vision. An interview with the Nursing Home Administrator (NHA) and Director of Nursing (DON) on August 7, 2025, at 11:13 AM revealed that Resident 60 has new glasses ordered but they are not paid for yet. The NHA confirmed that Resident 60 is paying for her new glasses out of her monthly personal needs allowance (money received by Medicaid residents in a nursing home for personal expenses, $60.00 dollars). Review of Resident 60's Resident trust statement revealed that January 7 to June 24, 2025, revealed a deduction on February 24, 2025, of 78.96 dollars for a medical bill, a deduction on March 13, 2025, of 60.00 dollars for a medical bill, and a deduction on May 8, 2025, of 243.00 dollars for an insurance premium. Interview with the Nursing Home Administrator on May 7, 2025, at 2:12 PM revealed that the deductions in the amount of 78.96 dollars and 60.00 dollars out of Resident 60's resident trust account were to pay for her glasses and the deduction for 243.00 dollars was to pay for her insurance that covers ancillary services such as dental, vision, and podiatry. The NHA indicated that the funds should have come out of Resident 60's patient liability amount (the amount a resident is obligated to pay the facility monthly) as an other medical expense and she indicated the facility will reimburse Resident 60 for the above noted expenses. The NHA also indicated that she spoke with the eye doctor regarding Resident 60's glasses and they were not ordered yet because they do not order them until at least half the money for the glasses is paid. The NHA was made aware with concerns related to Resident 60's personal fund account during a meeting on August 7, 2025, at 2:12 PM The facility failed to ensure Resident 60's personal fund trust account, and her personal needs allowance was utilized appropriately. 28 Pa. Code 201. 18(b)(2)(e)(1) Management28 Pa. Code 201.29(a) 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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. Based on clinical record review and staff interview, it was determined that the facility failed to provide required notification to a resident whose Medicare covered services ended for one of three residents reviewed (Resident 107). Findings include: A review of the form Instructions for the Notice of Medicare Non-Coverage (NOMNC) CMS-10123, (a notice that informs the recipient when care received from the skilled nursing facility is ending; and how to contact a Quality Improvement Organization (QIO) to appeal) revealed instructions that a Medicare provider must ensure that the notice is delivered at least two calendar days before Medicare covered services end. The provider must ensure that the beneficiary or their representative signs and dates the NOMNC to demonstrate that the beneficiary or their representative received the notice and understands the termination of services can be disputed. If the provider is personally unable to deliver a NOMNC to a person acting on behalf of an enrollee, then the provider should telephone the representative to advise him or her when the enrollee's services are no longer covered. Confirm the telephone contact by written notice mailed on that same date. Clinical record review for Resident 107 revealed census documentation that indicated the facility admitted her for services paid for by Medicare A on February 14, 2025. The facility discharged Resident 107 to her home/self-care on March 14, 2025. Social services documentation dated March 7, 2025, at 11:21 AM revealed that Resident 107 was making excellent progress with therapy goals and had the potential to discharge to home within seven days. Social services documentation dated March 12, 2025, at 9:53 AM revealed that therapy was recommending home physical therapy for Resident 107's transition to home. Social services documentation dated March 12, 2025, at 12:26 PM revealed that the facility forwarded a referral for home health services to a provider of home health services, and Resident 107's discharge was on track for Friday (March 14, 2025). Social services documentation dated March 14, 2025, at 8:00 AM revealed that Resident 107 discharged home. Interview with the Nursing Home Administrator on August 8, 2025, at 10:15 AM revealed that the facility did not have evidence that Resident 107 received the CMS-10123 notice two days before her discharge from the facility. 28 Pa. Code 201.18(b)(2)(e)(1) Management 28 Pa. Code 201.29(a) Resident rights

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. Based on observation, review of resident council meeting minutes, and resident and staff interview, it was determined that the facility failed to ensure resident grievances were addressed timely for one of 13 residents interviewed (Resident 2).Findings include: Interview with Resident 2 on August 5, 2025, at 12:46 PM revealed that she asked for cups of hot water for her hot chocolate and the cups are stained brown. Observation of the clean racks of coffee cups in the kitchen on August 6, 2025, at 10:44 AM with Employee 6 (dietary supervisor) revealed that most of the cups were stained brown. Employee 6 stated that an evening shift dietary staff member is supposed to clean the cups once a week, by soaking and scrubbing them. She stated that the staff are to sign off on the cleaning of the coffee cups weekly. Review of the weekly cleaning tasks documentation for June 23, June 30, July 7, July 14, July 28, and August 4, 2025, revealed staff only de-stained the coffee cups on June 30, and July 23, 2025. Employee 6 confirmed these findings on August 6, 2025, at 10:51 AM. Review of the Resident Council Meeting minutes dated April 28, 2025, revealed residents' concerns about dirty utensils, glasses, and coffee cups remain. Resident Council Meeting minutes dated June 16, 2025, revealed resident dietary concerns are ongoing, and feel that the same concerns from the prior meetings still currently exist. Resident Council Meeting minutes dated July 28, 2025, revealed that the residents' concerns about dirty coffee cups remain. The facility failed to resolve the residents' grievances related to stained coffee cups. The surveyor reviewed the above findings during an interview with the Nursing Home Administrator and Director of Nursing on August 6, 2025, at 2:00 PM. 28 Pa. Code 201.14(a) Responsibility of licensee28 Pa Code: 201.18(b)(2)(3)(e)(1) Management28 Pa. Code 201.29(a) Resident rights28 Pa. Code 211.12(d)(3)(5) Nursing services

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. Based on review of select facility policies and procedures, employee personnel records, and staff interview, it was determined that the facility failed to implement an abuse prohibition policy that required a thorough investigation of prospective employee's employment history for two of five newly hired employees reviewed (Employees 3 and 4).Findings include: The facility policy entitled Abuse, Neglect, Exploitation and Misappropriation of Resident Property, last reviewed without changes December 10, 2024, revealed it is the policy of the facility to undertake background checks of all employees and to retain on file applicable records of current employees regarding such checks. The facility would attempt to obtain reference checks from prior employees for an applicant. Review of the facility policy entitled Reference Check Request Policy, last reviewed December 10, 2024, revealed the Administrator will be responsible for ensuring that each applicant seeking employment with the facility will be required to complete a release regarding reference checks. Upon receipt of satisfactory evidence of the reference checks, and pending other compliance standards are met, an offer of employment will be made. If receipt of unsatisfactory evidence of the reference check is found, then the applicant will be notified that the offer to employ them will be withdrawn. Review of Employee 3's (housekeeper) personnel record revealed a hire date of June 18, 2025. Employee 3's personnel record contained no evidence that the facility attempted to obtain personal and/or professional reference information (whether favorable or unfavorable). Review of Employee 4's (cook) personnel record revealed a hire date of April 14, 2025. Employee 4's personnel record contained no evidence that the facility attempted to obtain personal and/or professional reference information (whether favorable or unfavorable). Employee 5 (human resources) confirmed these findings for Employees 3 and 4 on August 7, 2025, at 11:45 AM. The findings were reviewed with the Nursing Home Administrator on August 7, 2025, at 12:31 PM. 28 Pa. Code 201. 18(b)(3) Management 28 Pa. Code 201.19 Personnel policies and procedures

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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. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, review of facility documentation, and staff interview, it was determined that the facility failed to thoroughly and timely investigate and implement interventions after a resident elopement for one of three residents reviewed (Resident 52). Findings include: Clinical record review revealed Resident 52 was admitted to the facility on [DATE]. An elopement evaluation completed the same day indicated the resident had a history of elopement (leaving unsafely) at home and had wandering behavior. A social service note dated May 30, 2025, indicated the resident had severely impaired cognition related to Alzheimer's disease, had the ability to ambulate without a device, may wander, and was to be monitored for exit-seeking. A social service note dated June 3, 2025, at 8:10 AM revealed that Resident 52 was reviewed by the inter-disciplinary team and was disoriented with poor safety awareness, can ambulate without a device and noted as an elopement risk as evidenced by wandering from her home prior to admission. It was noted to start secure care (a band/bracelet wandering device worn to prevent exit from doors at the facility) and monitor for adjustment. It was noted secure care applied for safety. Further clinical record review for Resident 52 revealed a note dated June 15, 2025, at 3:45 PM indicating facility staff received a call from staff from a hospital across the road from the facility indicating Resident 52 was found there walking around the helipad (location for emergency care helicopters to land) at the hospital. Facility staff went to retrieve the resident and bring her back to the facility. The resident was assessed with no injuries, and a secure care should be on the resident's right ankle. Frequent checks were initiated by nursing at that time. Review of a facility document regarding the incident dated June 15, 2025, at 3:25 PM completed by facility staff noted at 3:20 PM a nursing staff supervisor from the hospital across the road from the facility called the facility notifying them that there was a person with an ankle bracelet walking on the helipad and told them her name, and was asking if the facility had a resident with that name. Facility staff notified the Director of Nursing immediately and the building was searched to locate the resident. A facility staff member went to the hospital to pick the resident up and the resident was back in the facility at 3:40 PM. Every 15-minute observation checks were initiated. There was no documentation provided during the onsite visit to indicate 15-minute checks were completed as noted on the incident investigation on June 15, 2025. Although the facility completed an elopement drill after the incident on the same day on June 15, 2025, there was no evidence of an investigation that revealed how Resident 52 exited the facility with a secure care device on and crossed the road to hospital property until June 17, 2025, two days later. There was no evidence of any all-staff education being implement regarding the elopement or how to prevent the resident or other residents from eloping until June 16, 2025. Nursing documentation dated June 16, 2025, at 9:42 PM revealed Resident 52 had exit seeking behaviors during the 3 PM to 11pm shift with a suitcase packed, was leaving, became physically abusive towards staff, and slapped a staff member when being redirected. There was no evidence of any change in interventions or documentation of every 15-minute checks as the resident continued to exit seek. There was still no evidence of a thorough investigation regarding how Resident 52 was able to exit the facility on June 15, 2025. There was no evidence of any staff statements regarding Resident 52's elopement until June 17, 2025, when it was noted activity staff were present when Resident 52 eloped and assumed to have turned off the door alarm as the secure care is designed to alarm when a device is passing through the door. The staff member did not report the alarm sounding when church volunteers left for the day. There was no evidence all facility staff were then educated on how to respond to the door alarms. There was no evidence of secure care checks on the front door of the facility where the resident exited until June 17, 2025. The above information was reviewed with the Nursing Home Administrator on August 8, 2025, at 12:22 PM. 8 Pa. Code 201.18(b)(1)(e)(1) Management 28 Pa. Code 211.10(c)(d) Resident care policies 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 interview, it was determined the facility failed to initiate timely interventions for a resident with significant weight loss for one of six residents reviewed for nutrition concerns (Resident 52). Findings include: Clinical record review for Resident 52 revealed the resident had a weight change from June 17, 2025, to July 17, 2025, decreasing from 135.2 pounds to 125.6 pounds reflecting a 9. 6-pound, 7.1 percent significant weight loss in 30 days. Further clinical record review revealed a nutrition services note by the registered dietitian dated July 21, 2025, at 6:13 PM that noted the significant weight loss as indicated above and indicated the resident had a decline in meal intakes. The note indicated Boost (nutrition supplement) would be added twice a date for the resident to provide extra calories and fluid to help the resident meet nutritional needs. A review of Resident 52's physician orders revealed Boost two times a day was not ordered for the resident until July 31, 2025, 10 days later. There was no evidence Resident 52 was provided the nutrition supplement prior to this date. As of August 8, 2025, there was no evidence to indicate any further nutrition follow up or any indication explaining that the supplement added on July 21, 2025, was not ordered/provided until July 31, 2025. Resident 52 had refused to be weighed after the July 17, 2025, weight. The above information was reviewed with the Nursing Home Administrator on August 8, 2025, at 11:30 AM. 28 Pa. Code 211.10(d) Resident care policies 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. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 appropriate enhanced barrier precautions for two of 19 residents reviewed (Residents 12 and 13) and implement appropriate transmission-based precautions (TBP) for one of one resident reviewed on TBP (Resident 25). Findings include: Review of the Centers for Medicare and Medicaid Services (CMS) memo entitled, Enhanced Barrier Precautions in Nursing Homes, dated March 20, 2024, revealed that CMS was issuing new guidance for State Survey Agencies and long-term care (LTC) facilities on the use of enhanced barrier precautions (EBP) to align with nationally accepted standards. In 2019, CDC (Centers for Disease Control) introduced a new approach to the use of personal protective equipment (PPE) called Enhanced Barrier Precautions (EBP). In July 2022, the CDC released updated EBP recommendations for Implementation of PPE Use in nursing homes to prevent spread of MDROs. The CDC's, Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs), stipulated that, When implementing Contact Precautions or Enhanced Barrier Precautions, it is critical to ensure that staff have awareness of the facility's expectations about hand hygiene and gown/glove use, initial and refresher training, and access to appropriate supplies. To accomplish this post clear signage on the door or wall outside of the resident room indicating the type of precautions and required PPE (e.g., gown and gloves). For Enhanced Barrier Precautions, signage should also clearly indicate the high-contact resident care activities that require the use of gown and gloves. Nursing care facilities are to use enhanced barrier precautions (EBP, gown and glove use) for residents with chronic wounds or indwelling medical devices (i.e., indwelling urinary catheters) during high-contact resident care activities regardless of their multidrug-resistant organism status. High-contact activity would include things like dressing, transferring, changing linens, providing hygiene, changing briefs, wound care, or device care. Review of CDC guidance at https://www.cdc.gov/long-term-care-facilities/hcp/prevent-mdro/faqs.html, Frequently Asked Questions (FAQs) about Enhanced Barrier Precautions in Nursing Homes, revealed that signs are intended to signal to individuals entering the room the specific actions they should take to protect themselves and the resident. To do this effectively, the sign must contain information about the type of precautions and the recommended PPE to be worn when caring for the resident. Generic signs that instruct individuals to speak to the nurse are not adequate to ensure precautions are followed. CDC has created examples of signs that can be used by facilities to communicate information about Transmission-Based and Enhanced Barrier Precautions. Facilities can use these signs or modify them to create signs that work for their facility. Review of CDC guidance at https://www.cdc.gov/long-term-care-facilities/media/pdfs/Observations-Tool-for-Enhanced-Barrier-Precautions-Implementation-508.pdf, Enhanced Barrier Precautions (EBP) Implementation-Observations Tool (For use in Skilled Nursing Facilities/Nursing Homes only) reiterated that signs are intended to signal to individuals entering the room the specific actions they should take to protect themselves and the resident. To do this effectively, the sign must contain information about the type of precautions and the recommended PPE to be worn when caring for the resident. The EBP sign should also include a list of the high-contact resident care activities for which PPE (gown and gloves) should be worn. Generic signs that instruct individuals to speak to the nurse are not adequate to ensure EBP are followed. Signs should not include information about a resident's diagnosis or the reason for the use of EBP (e.g., presence of a resistant germ, wound). A review of the CDC sign for EBP revealed that the first directive is that everyone must clean their hands, including before entering and when leaving the room. Review of the facility policy entitled, Enhanced Barrier Precautions, last reviewed without changes on December 10, 2024, revealed that it is the policy of the facility to use EBP to prevent transmission of MDROs from an infected or colonized resident through an infection control intervention designed to reduce transmission of resistant organisms that employs targeted gown and glove use during high contact resident care activities. An impervious gown should be worn when high-contact resident care activities are being performed. The policy did not address the placement of a sign to signal to individuals entering the room the specific actions they should take to protect themselves and the resident. Clinical record review for Resident 12 revealed current physician orders dated July 8, 2025, for staff to complete a dressing change to a G-tube (gastrostomy 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) every day and evening shift. Observation of Resident 12's room on August 5, 2025, at 1:25 PM