

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

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395699	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/24/2026
NAME OF PROVIDER OR SUPPLIER Sweden Valley Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 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 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 in accordance with professional standards for food service safety in the facility's main kitchen and resident pantry area. Findings include: Observation of the facility's main kitchen on July 21, 2026, at 10:30 AM, with Employee 15, dietary services supervisor, revealed the following: A small metal pan of a prepared product resembling tuna salad, on the bottom shelf of the reach-in refrigerator, with no label to identify the product, a date of when it was placed there or when it needed used by. Front vents on the bottom of the outside of the reach-in refrigerator were observed to have various spills down the face of this area. The juice machine with an observable filter inside the machine, presented with build-up. A green plastic basket under the steam table contained numerous grape jelly and apple jelly packets. The basket did not contain any date as to when the packets needed used by or when the expire. A clear blue plastic container of saltine cracker packets was observed under the steam table, containing sticky substances on the cracker packets with no label, date the crackers were received or when they needed discarded by. Four single serve boxes of flavored drink packets, belonging to staff, were observed on the windowsill in the main kitchen with one box observed to have a use by date of November 2024. A plastic container of adaptive silverware and a separate plastic container of adaptive plates and bowls was observed stored on the bottom shelf in the food production area of the kitchen uncovered with food contact surfaces exposed to the potential contamination from dust, food splatter and debris. Debris was observed around the oven and steamer. A random stack of cloth towels was observed stored on top of several cutting boards that were standing upright in a rack, and on top of a metal stand, where the microwave and toaster are stored. A toaster was observed to have burnt debris inside of it. The bottom shelf of a metal stand, holding the microwave and toaster, contained clear plastic serving style containers with debris on them. The tops of soup cans on a shelving unit and the bottom shelf of the same shelving unit in the dry storage area were observed with debris. Two air vents in the ceiling and the vents of the door going into the storage room from the main kitchen had a build-up of dust. A clear, round container of a substance noted as flour, was dated May 13, 2026, there was no evidence to indicate if that was the date the flour was placed in the container or when it needed to be used by. This container was also observed with a yellowish colored substance dried on the outside of the container. Cobwebs were observed around the doorframes of the walk-in freezer and the kitchen exit doorway to the dumpster area. Two packaged cases of bottled water, plus one single bottle of water, were observed stored directly on the floor, under the shelving units in the dry storage area. A square black plastic container, in the walk-in freezer, that was broken with jagged pieces was observed to be holding single serve ice cream containers. Two packs of orange colored round vegetables (identified as yellow zucchini) were observed in the freezer with no label indicating what the item was, or when the product needed used (continued on next page)		

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	strips present. The above information was reviewed in a meeting with the Nursing Home Administrator and Director of Nursing on July 22, 2026, at 2:50 PM, and a meeting with the Nursing Home Administrator and Employee 5, registered nurse, on July 24, 2026, at 10:40 AM. 28 Pa. Code 201.14 (a) Responsibility of Licensee		

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. Based on a review of facility documentation and staff interview it was determined that the facility failed to conduct and document a facility-wide assessment to determine what resources are necessary to care for its residents since their last standard survey (ending August 8, 2025). Findings include: The surveyor requested the Facility Assessment document (Assessment of the resident population that includes an evaluation of diseases, conditions, physical or cognitive limitations of the resident population's acuity and any other pertinent information about the residents that may affect the services the facility must provide. The assessment of the resident population contributes to the identification of staffing decisions and inform the facility about what skills and competencies staff must possess in order to deliver the necessary care required by the residents being served on any given day,) during interviews with the Nursing Home Administrator on July 21, 2026, at 10:47 AM; July 22, 2026, at 2:00 PM, and July 23, 2026, at 2:00 PM. Interview with the Nursing Home Administrator and Employee 5 (registered nurse) on July 24, 2026, at 10:30 AM confirmed that the facility had no evidence of a Facility Assessment (that would identify education and skill sets necessary for nursing staff providing resident care) until after the surveyor's requests for the document. 28 Pa. Code 201.14(a)(j) Responsibility of licensee 28 Pa. Code 201.18(e)(1)(3) Management 28 Pa. Code 201.20(a)(6) Staff development		

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F 0628 Level of Harm - Minimal harm or potential for actual 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) or legal representative of the reason for discharge, in writing, upon discharge from the facility for three of four sampled residents who were transferred out of the facility. (Residents 4, 9, and 117) Findings include: Clinical record review revealed that Resident 4 was transferred to the hospital on July 13, 2026, after a change in condition. There was no documented evidence that the resident and resident's responsible party, or the legal representative, were notified in writing of the transfer. Clinical record review revealed that Resident 9 was transferred to the hospital July 13, 2026, after a change in condition. There was no documented evidence that the resident and resident's responsible party, or the legal representative, were notified in writing of the transfer. Clinical record review revealed that Resident 117 was transferred to the hospital on July 18, 2026, after a change in condition. There was no documented evidence that the resident and resident's responsible party, or the legal representative, were notified in writing of the transfer. Interview with the Nursing Home Administrator and Employee 5, Registered Nurse, on July 23, 2026, at 2:00 PM confirmed that the facility had no evidence they notified the resident and the resident's representative(s) or legal representative of the reason for discharge, in writing, upon discharge from the facility. 28 Pa. Code 201.14(a) Responsibility of licensee.		

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. Based on review of select facility policies and procedures, clinical record review, and staff interview, it was determined that the facility failed to have sufficient nursing staff to provide nursing services to maintain the highest practicable standard of care related to medication administration on two of four hallways (B and D Hallway; Residents 7, 14, 15, 20, 26, 29, 37, 42, 41, 43, 44, 46, 55, 56, 61, 62, 70, 72, 88, 93, 94, 95, 96, 97, 117, and 118). Findings include: The current facility policy titled Medication Administration - General Guidelines states that medications are to be administered within 60 minutes of scheduled time. Interview on July 23, 2026, at 9:00 AM with Employee 9, licensed practical nurse, revealed that she had only begun to administer the morning medications on D Hallway because she was assigned two halls of morning medication passes. When asked if this happened often, Employee 9 said it was happening more and more. Clinical record review of the residents on D Hallway revealed that the following residents had morning medications ordered with an administration time of 8:00 AM on July 23, 2026; Residents 7, 14, 15, 20, 26, 29, 41, 42, 43, 44, 46, 55, 56, 61, 70, 72, 88, 93, 94, 95, 96, 97, and 118. These residents had not been administered the medications as of the time of the above interview and observation with Employee 9. Review of facility nurse staffing provided by the facility for July 23, 2026, indicated only 2.5 licensed practical nurses were scheduled for the dayshift. Interview with Employee 8, licensed practical nurse, on July 24, 2026, at 11:10 AM revealed they were still passing medications on B Hallway for the 8:00 AM morning medication pass. Employee 8 stated that when they do not have four nurses (a nurse assigned to each of the four hallways), they are always late with the morning medications. Clinical record review of the residents on B Hallway revealed that Residents 37, 62, and 117, had not received their morning medications on July 24, 2026, within 60 minutes of the 8:00 AM scheduled administration time. Review of facility nurse staffing provided by the facility for July 24, 2026, revealed that the facility had three licensed practical nurses scheduled to work on July 24, 2026. The Nursing Home administrator and Employee 5, registered nurse, were made aware of the above information on July 24, 2026, at 12:00 PM. 28 Pa. Code 211.12(f.1)(4) LPN Minimum Staff 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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. Based on review of facility documentation, clinical record review, and review of personnel training records, it was determined that the facility failed to ensure specific competencies necessary to care for resident needs for nine of 10 employees reviewed (Employees 4, 6, 9, 11, 12, 13, 14, 19, and 20); and for one of one resident reviewed for peritoneal dialysis concerns (Resident 117). Findings include: The surveyor requested the Facility Assessment document (Assessment of the resident population that includes an evaluation of diseases, conditions, physical or cognitive limitations of the resident population's acuity and any other pertinent information about the residents that may affect the services the facility must provide. The assessment of the resident population contributes to the identification of staffing decisions and inform the facility about what skills and competencies staff must possess in order to deliver the necessary care required by the residents being served on any given day.) during interviews with the Nursing Home Administrator on July 21, 2026, at 10:47 AM, July 22, 2026, at 2:00 PM, and July 23, 2026, at 2:00 PM. The surveyor requested the facility provide a list of qualified staff providing assistance for peritoneal dialysis treatments (a medical procedure to remove excess water and waste from the body through a catheter inserted into the lining of the abdomen) within four hours of the survey entrance conference interview with the Nursing Home Administrator and the Director of Nursing on July 21, 2026, at 10:47 AM. The interview indicated that the facility permits licensed practical nurses (LPNs) to take verbal orders from physicians, and that the facility currently provides services to a resident who required peritoneal dialysis (Resident 117). Clinical record review for Resident 117 revealed a treatment administration record (TAR, the electronic documentation completed by licensed staff for the completion of treatments) dated July 2026 that indicated peritoneal dialysis treatments started at 10:00 PM and discontinued at 7:00 AM daily. The initials on the TAR indicated that licensed practical nurses (Employees 4, 14, 19, 20) administered the required treatments. Interview with the Nursing Home Administrator and the Director of Nursing on July 22, 2026, at 2:00 PM confirmed that the facility did not have evidence that all staff that assist Resident 117 with peritoneal dialysis treatments have completed competency evaluations. The facility was unable to provide evidence for the competencies for Employees 4, 14, 19, and 20. The surveyor requested evidence of competency assessments related to feeding, bathing, and resident transfer (to include the use of mechanical lifts) for Employee 11 (nurse aide), Employee 12 (nurse aide), and Employee 13 (nurse aide), during an interview with the Nursing Home Administrator and Employee 5 (registered nurse) on July 23, 2026, at 2:00 PM. The interview indicated that the facility did not staff a registered nurse (RN) on second shift on every day and that a licensed practical nurse (LPN) was the charge nurse on second shift on many days. The interview indicated that the facility scheduled an on-call RN when the LPN was charge nurse; however, the facility could not provide evidence that LPN staff were educated regarding this staffing plan and protocol. The surveyor requested competency assessments related to medication administration and responding to changes in resident condition for Employee 9 (LPN) and Employee 14 (LPN). The surveyor requested competency assessments related to medication administration, peritoneal dialysis, and responding to changes in resident condition for Employee 6 (RN). Interview with the Nursing Home Administrator and Employee 5 (registered nurse) on July 24, 2026, at 10:30 AM confirmed that the facility was unable to provide evidence of NA competencies for Employees 11, 12, or 13. The facility was unable to provide evidence of LPN competencies for Employees 9 or 14. The facility was unable to provide evidence of RN competencies for Employee 6. The interview with the Nursing Home Administrator and (continued on next page)		

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Employee 5 on July 24, 2026, at 10:30 AM confirmed that the facility had no evidence of a Facility Assessment (that would identify education and skill sets necessary for nursing staff providing resident care) until after the surveyor's requests for the document. 28 Pa. Code 201.19(7) Personnel policies and procedures 28 Pa. Code 201.20(a)(6)(d) Staff development 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services		

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. Based on review of select facility policies and procedures, clinical record review, and staff interview, it was determined that the facility failed to ensure an appropriate, timely, physician response to consultant pharmacist recommendations for two of five residents reviewed (Residents 5 and 12). Findings include: The facility policy entitled, Medication Regimen Review and Recommendation, last reviewed without changes on December 3, 2025, noted that non-emergent recommendations are to be addressed within the next 30 days. If a recommendation has not been answered within 30 days, the consultant will notify the Director of Nursing that the recommendation is still pending. If after 60 days, there is still no response, the recommendation will be made again. Interview with the Nursing Home Administrator and the Director of Nursing on July 22, 2026, at 2:00 PM revealed that monthly consultant pharmacist reviews are documented in residents' physical charts on the nursing unit (not in the electronic medical record). Review of Resident 5's physical chart on the nursing unit revealed no evidence of a consultant pharmacist review after April 14, 2026 (no documentation for May, June, or July 2026). The surveyor requested evidence of the monthly consultant pharmacist reviews after April 14, 2026, for Resident 5 during an interview with the Nursing Home Administrator and Employee 5 (registered nurse) on July 23, 2026, at 2:00 PM. A Note to Attending Physician/Prescriber report dated May 14, 2026 (provided by the facility the morning of July 24, 2026), requested that the physician provide a diagnosis to warrant Resident 5's use of Amiodarone (medication used to treat irregular heart rhythms) with a comment regarding the benefits versus the risk. Interview with the Nursing Home Administrator on July 24, 2026, at 10:30 AM confirmed that the facility had no evidence of a physician response to the consultant pharmacist's request dated May 14, 2026. Clinical record review for Resident 5 revealed an active physician order dated January 28, 2026, for staff to apply Voltaren gel every six hours as needed for bilateral shoulder pain. A Note to Attending Physician/Prescriber report dated June 10, 2026 (provided by the facility the morning of July 24, 2026), requested that the facility staff discontinue Resident 5's Voltaren gel (topical gel used to treat localized pain) medication due to non-use. Interview with the Nursing Home Administrator on July 24, 2026, at 10:30 AM confirmed that the facility had no evidence of a response to the consultant pharmacist's request dated June 10, 2026. Clinical record review for Resident 12 revealed a consultant pharmacist report dated September 22, 2025, that requested that Resident 12's physician complete a semi-annual evaluation for the continued use of Zoloft (Sertraline, an antidepressant) and Haldol (an antipsychotic). The physician's response on October 13, 2025, noted that Resident 12's psychotropic medications were managed by psychiatry. A consultant pharmacist report dated October 21, 2025, requested that Resident 12's physician complete a semi-annual evaluation for the continued use of Trazodone (an antidepressant) and Clonazepam (an antianxiety medication). The physician's response on October 31, 2025, again noted that Resident 12's psychotropic medications were managed by psychiatry. Resident 12's clinical record contained progress note documentation by the facility's contracted psychiatry provider dated July 22, 2025, and May 11, 2026. There was no evidence that the facility's contracted psychiatry provider responded to the consultant pharmacist's recommendation dated September 22, 2025, or October 21, 2025. A consultant pharmacist report dated March 19, 2026, requested that Resident 12's physician evaluate Resident 12's psychotropic drug therapy medications (due for evaluation of dose decrease, increase, or change in therapy): Sertraline (Zoloft, an antidepressant), Trazodone, Topamax (anti-seizure medication), Clonazepam (an antianxiety medication), Wellbutrin (an antidepressant), and Haldol (an antipsychotic). The physician's (continued on next page)		

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	response dated May 4, 2026 (more than a month later), instructed to address the report with psychiatry. A May 11, 2026, progress note (almost two months from the date of the consultant pharmacist report dated March 19, 2026) from the facility's psychiatric provider did not reference the consultant pharmacist report dated March 19, 2026. The surveyor reviewed the above concerns related to Resident 12's consultant pharmacist recommendations during interviews with the Nursing Home Administrator and Employee 5 (registered nurse) on July 23, 2026, at 2:00 PM and July 24, 2026, at 10:30 AM. 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 - Some	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 appropriate enhanced barrier precautions for one of 22 residents reviewed (Resident 117), and failed to ensure an environment free from the potential spread of infection related to resident laundry processing. Findings include: Review of a current facility document titled EBP (Enhanced Barrier Precautions) states that the facility will utilize enhanced barrier precautions that includes residents who have indwelling medical devices (items that stay in the body for a long time to help treat illness, drain fluid, or replace body parts). The document states that EBP will include signage outside the doorway and requires the use of gloves and gowns for any high contact resident care activities. The document further states that each room will have a hanging storage bag for gowns, and a closed receptacle for used gowns. Clinical record review for Resident 117 revealed they had an indwelling medical device inserted into their abdomen for peritoneal dialysis treatments. Further review revealed no physician order for the use of Enhanced Barrier Precautions. Observation of Resident 117's room on July 21, 2026, at 10:40 AM revealed no signage outside their room to indicate they were on EBP. No storage of gowns or gloves, or a receptacle to dispose of used supplies was observed inside or outside the resident's room. Continued observation on July 22, 2026, at 11:30 AM also revealed no EBP signage or supplies and disposal receptacle. During an interview with Employee 22, licensed practical nurse, on July 23, 2026, at 3:25 PM, she stated that without a physician's order, and sign and supplies outside the door, she would not know that the resident was on/required EBP. Concurrent interview with Employee 23, nurse aide, she stated that she has never worn a gown when caring for the resident, because she did not know she was on EBP. Above findings discussed with the Nursing Home Administrator and Employee 5, registered nurse on July 24, 2026, at 2:30 PM. Interview with Employee 24, laundry aide, on July 22, 2026, at 12:35 PM revealed that they filled the washing machines up to the top where their hand just fits inside. When asked if they have ever weighed loads of laundry, they indicated that they did for the old washing machines, but the new ones do not require it. Employee 24 stated there was no operating manual for the washing machines in the laundry room and indicated that maintenance would have this information. Maintenance provided the model number for the washing machines (Milnor E-P Express 30022T6X), and a review of the brochure for this model number, found on www.milnor.com, indicated that this model number had a capacity of 60 pounds. The Nursing Home Administrator was made aware of the above findings related to the laundry on July 24, 2026, at 9:30 AM. 483.80(a)(1)(2)(4)(e)(f) Infection Prevention and Control Previously cited deficiency 8/8/25 28 Pa. Code 211.12(d)(1)(5) Nursing services		

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, and resident and staff interview, it was determined that the facility failed to ensure residents were offered the pneumococcal and influenza immunization unless contraindicated for three of five residents reviewed for immunizations (Residents 3, 16, and 59). Findings include: Current CDC website information notes that there are four pneumococcal vaccines available in the United States. Pneumococcal conjugate vaccines (PCVs: PCV15, PCV20 (Pneumovax20), and PCV21) and pneumococcal polysaccharide vaccine (PPSV23). Each of these vaccines helps protect against specific serotypes, or strains, of pneumococcal bacteria. The number at the end of the vaccine name tells how many strains the vaccine includes. CDC Pneumococcal Vaccine Timing for Adults (https://www-new.cdc.gov/pneumococcal/downloads/Vaccine-Timing-Adults-JobAid.pdf) instructs that a complete series would be a PCV13 (Pneumovax 13, pneumococcal conjugate vaccine) at any age, a PPSV23 (Pneumovax 23, pneumococcal polysaccharide vaccine) at greater than or equal to 65 years, and together with the resident, vaccine providers may choose to administer PCV20 (Pneumovax 20, 20-valent pneumococcal conjugate vaccine) or PCV21 (CAPVAXIVE, 21-valent conjugate vaccine) to adults greater than or equal to [AGE] years old who have already received the PCV13 (but not PCV15, PCV20, or PCV21) at any age and PPSV23 at or after the age of [AGE] years old. The CDC stipulates that, Based on shared clinical decision-making, decide whether to administer one dose of PCV20 or PCV21 at least 5 years after the last pneumococcal vaccine dose. Current CDC information indicates that for someone greater than [AGE] years old, with no known prior pneumococcal vaccines, the first option is to administer the PCV20 or PCV21; and the second option is to administer the PCV15 followed by the PPSV23 after greater than one year. Clinical record review for Resident 16 revealed that the facility admitted them on June 28, 2021, when they were [AGE] years old. Review of Resident 16's immunization history revealed that they received the Pneumovax (also known as PPSV23) after their admission to the facility, on July 2, 2021. Resident 16's clinical record contained no evidence that Resident 16 received any additional pneumococcal vaccinations in the five years since their last immunization. No Pneumococcal Immunization Consent/Declination form for Resident 16 was provided by the facility for the pneumococcal vaccine. Per CDC guidelines, Resident 16 should have received one dose of PCV15, PCV20 or PCV21 immunization at least one year after the last dose of PPSV23. Interview with Resident 16 on July 23, 2026, at 1:48 PM revealed that they had never offered them a pneumococcal vaccine. Clinical record review of Resident 3's immunization documentation revealed no historical data that indicated the resident had been offered or received any pneumococcal vaccinations, or that any Pneumococcal Immunization Consent/Declination information had been collected. Per CDC guidelines, the facility should have offered/administered the PCV15, PCV20, or PCV21 immunization to Resident 3. Resident 59's clinical record revealed they were admitted on [DATE]. Immunization documentation showed no indication that the resident received/refused their 2025 influenza vaccination, despite having received it the previous four years. The facility was unable to provide an influenza consent/declination form for resident 59, signed by the resident or resident's representative. The facility was unable to explain why the resident did not receive their influenza vaccination. Interview with Nursing Home Administrator and Employee 5, registered nurse, on July 23, 2026, at 2:30 PM, confirmed the above findings regarding pneumococcal and influenza immunizations for Residents 3, 16, and 59. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18(b)(1) Management 28 Pa. Code 211.12(d)(1)(5) Nursing services		

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. Based on clinical record review, facility documents, and staff interview, it was determined that the facility failed to ensure residents were educated and offered the COVID-19 immunization unless contraindicated for two of five residents reviewed for immunizations (Residents 3 and 59); and failed to maintain documentation related to staff COVID-19 vaccination education. Findings include: Interview with the Nursing Home Administrator and Employee 5, registered nurse on July 24, 2026, at 8:35 AM revealed that the facility had no evidence of facility documentation regarding staff COVID-19 immunization education. The interview indicated that the facility had no practice documenting staff COVID-19 immunization education. Clinical record review for Resident 3 revealed that the facility admitted them on July 4, 2026. There was no information in their chart indicating a history of COVID-19 immunization status, or if they had been offered COVID-19 immunization education. Resident 3's clinical record did not contain evidence that they received a COVID-19 vaccine. Clinical record review for Resident 59 revealed that the facility admitted them on March 21, 2024. Review of Resident 59's immunization record revealed historical data that the resident received the Covid-19 immunization in 2021. Further review revealed a COVID-19 Booster refusal dated February 2, 2024. No further evidence could be provided that the resident or the resident representative had been offered any COVID-19 vaccinations or education since that time. The Nursing Home Administrator was made aware of the above findings on July 23, 2026, at 2:30 PM. 28 Pa. Code 211.12(d)(1)(5) Nursing services		

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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 residents' medication regime was free from potentially unnecessary medication for one of five residents reviewed for medication regime review (Residents 12). Findings include: Clinical record review for Resident 12 revealed active physician orders for the following psychotropic medications: Haloperidol (antipsychotic medication) 5 mg (milligrams) two times a day related to schizoaffective disorder, bipolar type (schizoaffective disorder, bipolar type, is a rare mental illness characterized by psychotic symptoms such as hallucinations, delusions, and disorganized thinking, alongside mood episodes including mania and occasionally major depression), active since June 28, 2024 Wellbutrin (antidepressant) 100 mg by mouth one time a day related to schizoaffective disorder, bipolar type; personality disorder (mental health condition where people have a lifelong pattern of seeing themselves and reacting to others in ways that cause problems), bipolar disorder (mental health condition characterized by significant mood swings), major depressive disorder (mental health condition characterized by persistent feelings of sadness, loss of interest in activities, and various emotional and physical problems) recurrent, active since May 29, 2024 Sertraline (antidepressant) 200 mg one time a day related to major depressive disorder, recurrent, active since November 22, 2023 Trazodone (antidepressant) 150 mg by mouth one time a day related to major depressive disorder, recurrent, active since July 23, 2022 Topamax (Topiramate, anti-seizure medication) 25 mg by mouth one time a day for mood stabilizer related to schizoaffective disorder, bipolar type; personality disorder, active since July 23, 2022 Clonazepam (anti-anxiety medication) 1 mg by mouth two times a day related to anxiety disorder, active since February 13, 2023 Review of plans of care developed by the facility to address Resident 12's mental health diagnoses and psychoactive medication use revealed the following interventions: Psychotropic medication use, created on April 18, 2021 (revised December 13, 2023): Monitor behaviors and record every shift Monitor resident for side effects of medication use Notify physician of any adverse side effects Use of non-pharmacological interventions and document effectiveness. Mood problem, anxiety, major depression, personality disorder, schizoaffective disorder bipolar type, fixed delusions, history of cannabis (commonly known as marijuana) use, opioid dependency, alcohol use, panic disorder, altered neurological status, and poor family support, created April 15, 2021 (revised September 22, 2025): Administer medications as ordered: Haldol, Clonazepam, Sertraline, Wellbutrin, Trazadone, Topiramate Monitor/document for side effects and effectiveness. Behavioral health consults as needed, followed by tele psych Use of antidepressant medications Sertraline, Trazodone, and Wellbutrin, related to bipolar disorder, schizoaffective disorder, and personality disorder, created on June 9, 2025 Give antidepressant medications ordered by physician Monitor/document side effects and effectiveness Monitor/document/report to physician as needed ongoing signs and symptoms of depression unaltered by antidepressant meds: sad, irritable, anger, never satisfied, crying, shame, worthlessness, guilt, suicidal ideations, negative mood/comments, slowed movement, agitation, disrupted sleep, fatigue, lethargy, does not enjoy usual activities, changes in cognition, changes in weight/appetite, fear of being alone or with others, unrealistic fears, attention seeking, concern with body functions, anxiety, constant reassurance Resident 12's clinical record contained Psychoactive Drug Monthly Flow Records (document used by staff to record episodes of target behaviors and side effects of medications) for Resident 12's use of the antipsychotic Haldol; however, there was no evidence of ongoing target behavior monitoring or potential side effect monitoring for the (continued on next page)		

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	antidepressant and antianxiety medications used by Resident 12. Only three potential target behaviors (hallucinations, delusions, and agitation) were recorded on the monthly flow records. A consultant pharmacist report dated September 22, 2025, requested that Resident 12's physician complete a semi-annual evaluation for the continued use of Zoloft (Sertraline) and Haldol. The physician's response on October 13, 2025, noted that Resident 12's psychotropic medications were managed by psychiatry. A consultant pharmacist report dated October 21, 2025, requested that Resident 12's physician complete a semi-annual evaluation for the continued use of Trazodone and Clonazepam. The physician's response on October 31, 2025, again noted that Resident 12's psychotropic medications were managed by psychiatry. Resident 12's clinical record contained progress note documentation by the facility's contracted psychiatry provider dated July 22, 2025, and May 11, 2026. There was no evidence that the facility's contracted psychiatry provider responded to the consultant pharmacist's recommendation dated September 22, 2025, or October 21, 2025. A consultant pharmacist report dated March 19, 2026, requested that Resident 12's physician evaluate Resident 12's psychotropic drug therapy medications (due for evaluation of dose decrease, increase, or change in therapy): Sertraline, Trazodone, Topamax, Clonazepam, Wellbutrin, and Haldol. The physician's response dated May 4, 2026 (more than a month later), instructed to address the report with psychiatry. A May 11, 2026, progress note (almost two months from the date of the consultant pharmacist report dated March 19, 2026) from the facility's psychiatric provider did not reference the consultant pharmacist report dated March 19, 2026. The surveyor reviewed the above concerns related to the lack of ongoing behavior and potential side effect monitoring for Resident 12's psychoactive medications and routine reviews for potential gradual dose reductions during interviews with the Nursing Home Administrator and Employee 5 (registered nurse) on July 23, 2026, at 2:00 PM and July 24, 2026, at 10:30 AM. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services		

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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 family and staff interview, it was determined that the facility failed to ensure assessments accurately reflected a resident's status for three of 22 residents reviewed (Residents 6, 14, and 65). Findings include: Clinical record review for Resident 6 revealed a diagnoses list that included Parkinson's disease (progressive neurological disorder that affects movement due to degeneration of nerve cells in the brain) since October 1, 2023, contracture (permanent shortening of muscles, tendons, or other soft tissues that restrict normal joint movement and cause deformity) of the left hand since October 25, 2022, and contracture of muscle, unspecified, since November 8, 2021. An active physician's order dated September 15, 2023, instructed staff to place a carrot splint (soft, tubular, positioning device) to Resident 6's left hand every shift with gentle passive range-of-motion for management of hand range-of-motion. A quarterly MDS (Minimum Data Set, an assessment tool completed at specific intervals to determine resident care needs) dated January 6, 2026, identified that Resident 6 had range-of-motion (ROM) impairments of both upper extremities and both lower extremities. A quarterly MDS dated [DATE], assessed Resident 6 as having no ROM impairments. Nursing documentation dated May 21, 2026, at 1:18 PM indicated that Resident 6 returned from a pain management appointment that incorporated Botox injections (injections of the protein toxin from a bacterium that relaxes muscles and/or blocks nerve signals) for left arm and hand contractures. A quarterly MDS dated [DATE], assessed Resident 6 as having ROM impairments of both upper extremities and both lower extremities. Interview with the Nursing Home Administrator and Employee 5 (registered nurse) on July 23, 2026, at 2:00 PM confirmed that staff errantly coded Resident 6's April 8, 2026, MDS to indicate that she had no ROM impairments. Clinical record review for Resident 65 revealed a quarterly MDS dated [DATE], that indicated that she had received one insulin (injectable hormone, insulin, used to lower blood sugar) injection in the seven-day lookback period. Review of Resident 65's medication regime for May 2026 revealed no evidence that Resident 65 received insulin. Interview with the Nursing Home Administrator and Employee 5 on July 23, 2026, at 2:00 PM confirmed that staff errantly coded Resident 65's May 13, 2026, MDS to indicate that she had received insulin. Interview with Resident 14's husband on July 21, 2026, at 12:54 PM revealed that Resident 14 wears glasses, however, she lost her glasses while living at the facility and staff cannot find them. Clinical record review for Resident 14 revealed that the facility admitted her on April 10, 2026. Resident 14's profile picture in her electronic medical record revealed that she wore glasses. A nursing admission progress note dated April 10, 2026, at 4:30 PM indicated that Resident 14 had glasses; that she was wearing a corrective vision appliance on admission. An admission MDS assessment dated [DATE], noted that staff completed the assessment of Resident 14's vision while she was not wearing any corrective lenses (defined as contacts, glasses, or magnifying glass). Review of the Resident Assessment Instrument (RAI) manual for the vision section of the MDS assessment instructs that: Steps for Assessment include to ensure that the resident's customary visual appliance for close vision is in place (e.g., eyeglasses, magnifying glass). Planning for Care includes knowing if corrective lenses were used when determining the ability to see to allow better identification of evaluation and management needs. Residents with eyeglasses or other visual appliances should be assisted in accessing them. Use and maintenance should be included in care planning. Review of available plans of care for Resident 14 since her admission to the facility failed to provide evidence that the facility incorporated Resident 14's use of glasses in her plan of care. Interview with the Nursing Home Administrator and Employee 5 on July 24, 2026, at 10:30 AM (continued on next page)		

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

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	confirmed the above findings for Resident 14. The facility failed to ensure that Resident 14 wore typically used glasses during the completion of the MDS assessment and failed to include the use of glasses in her plan of care. 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, review of facility documentation, and staff and resident interview, it was determined that the facility failed to implement a comprehensive person-centered care plan for two of 22 residents reviewed (Residents 2 and 97). Findings include: Clinical record review for Resident 2 revealed a diagnosis list that included the presence of a cardiac pacemaker (an electronic device to help regulate the beating of the heart). A quarterly Minimum Data Set Assessment (MDS, an assessment completed at specific intervals to determine care needs) for Resident 2 dated May 17, 2026, revealed an active diagnosis of the presence of a cardiac pacemaker. Documentation dated March 31, 2026, at 5:16 PM revealed a chest x-ray that was completed and noted a pacemaker. Review of Resident 2's care plan revealed no current comprehensive, person-centered care plan that addressed the resident's pacemaker, any pertinent assessments related to the pacemaker and/or clinical care, or any associated precautions. The care plan related to Resident 2's pacemaker was requested during a meeting with the Nursing Home Administrator and Director of Nursing on July 22, 2026, at 2:00 PM. The facility later provided a pacemaker care plan for Resident 2 that was noted as created on July 22, 2026 (after discussion with the surveyor). The facility confirmed during a meeting with the Nursing Home Administrator and Employee 5, registered nurse, on July 23, 2026, at 2:00 PM that the resident did not previously have a care plan related to the pacemaker and it was added. The facility failed to implement comprehensive person-centered care plan for Resident 2's pacemaker. Interview with Resident 97 on July 22, 2026, at 10:31 AM, revealed the resident was having difficulty hearing the surveyor for the interview and kept pointing to her ears. The resident indicated she was waiting for staff to provide her hearing aids. Resident 97 expressed that she must specifically ask for her hearing aids and is often told they are not charged then she doesn't receive them for the day. The hearing aids were not kept in the resident's room. A quarterly Minimum Data Set Assessment (MDS, an assessment completed at specific intervals to determine care needs) for Resident 97 dated June 17, 2026, revealed a BIMS (Brief Interview for Mental Status, an assessment of cognitive status) score of 14, indicating the resident is cognitively intact. The assessment indicated no to the question as to whether the resident had hearing aids. A prior comprehensive MDS dated [DATE], for the resident indicated facility staff assessed the resident as having hearing aids. A follow up observation of Resident 97 on July 23, 2026, at 9:46 AM, revealed the resident did not have her hearing aids in her ears. Review of Resident 97's care plan revealed a plan of care indicating the resident uses hearing aids was initiated on March 13, 2026, and last updated on March 15, 2026. The interventions included the resident wears hearing aids, and to ensure availability and function of the hearing aids. Observation of Resident 97 on July 24, 2026, at 9:45 AM, again revealed the resident did not have any hearing aids in her ears. Concurrent interview with Employee 8, licensed practical nurse, confirmed Resident 97 did not have her hearing aids in. Resident 97 was not provided her hearing aids as indicated in the resident's plan of care. The above information was reviewed with the Nursing Home Administrator and Employee 5 on July 24, 2026, at 10:40 AM and again at 12:00 PM. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services		

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. Based on clinical record review and resident and staff interview, it was determined that the facility failed to provide care and services to maintain or improve the ability to perform activities of daily living for one of two residents reviewed for rehabilitation concerns (Resident 104). Findings include: Clinical record review for Resident 104 revealed a diagnoses list that included a displaced intertrochanteric fracture of the right femur (a type of broken hip). A Medicare 5-Day Minimum Data Set Assessment (MDS, an assessment completed at specific intervals to determine care needs) dated June 8, 2026, revealed that facility staff assessed Resident 104 as having a BIMS (Brief Interview for Mental Status) of 3, which indicated cognitive impairment. Review of clinical documentation revealed a PT (physical therapy) Daily Note dated July 2, 2026, at 12:00 AM which noted the physical therapy discharge report was completed and an RNP (Restorative Nursing Program) was developed. Documentation for Resident 104 titled, PT Discharge Summary, for June 30, 2026, to July 2, 2026, revealed a section titled Discharge Information that noted follow-up care recommended and listed Restorative Treatment. A daily note dated July 2, 2026, noted that an RNP was developed. Further review of the clinical record revealed no documentation that the restorative nursing program for Resident 104 was completed or attempted as recommended by physical therapy. The above information for Resident 104 was reviewed in a meeting with the Nursing Home Administrator and Director of Nursing on July 22, 2026, at 2:00 PM. A follow-up meeting with the Nursing Home Administrator and Employee 5, registered nurse, on July 23, 2026, at 2:00 PM revealed that the Nursing Home Administrator reported that physical therapy recommended a restorative program and it was not put into place. 28 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. **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 provide the highest practical care regarding ordered weights for two of seven residents reviewed for nutrition concerns (Residents 11 and 104). Findings include: Clinical record review for Resident 11 revealed that the resident was admitted to the facility on [DATE]. A current physician order for Resident 11 dated May 22, 2026, instructed staff to obtain weight every week for four weeks and then monthly and as needed. Clinical record review for Resident 11 revealed a care plan that noted a nutritional problem or potential nutritional problem related to the medical history. An intervention dated May 25, 2026, included weigh per orders, monthly, and as needed (PRN). Review of the current documented weights for Resident 11 revealed the weights were measured on May 22, 2026, June 30, 2026, and July 4, 2026. There were no documented weights for the weeks of May 25, 2026, June 1, 2026, June 8, 2026, June 15, 2026, or June 22, 2026. The above information for Resident 11 was reviewed in a meeting with the Nursing Home Administrator and Employee 5, registered nurse, on July 23, 2026, at 2:00 PM. The facility provided no further weight documentation for Resident 11. A follow-up meeting with the Nursing Home Administrator on July 24, 2026, at 10:56 AM revealed the facility could provide no further documentation related to Resident 11's missing weights. Clinical record review for Resident 104 revealed social services documentation dated June 4, 2026, at 9:42 PM that noted the resident was admitted to the facility. A current physician order for Resident 104 dated June 4, 2026, instructed staff to obtain admission weight and then weight every week for four weeks and then monthly and as needed. Clinical record review for Resident 104 revealed a care plan that noted a nutritional problem or potential nutritional problem related to the medical history. An intervention dated June 8, 2026, included weigh per orders, monthly, and as needed (PRN). Another intervention dated June 8, 2026, noted to monitor/record/report to the physician as needed signs / symptoms of malnutrition: emaciation (cachexia), muscle wasting, significant weight loss which included three pounds in one weeks; greater than five percent in one month; greater than 7.5 percent in three months; greater than ten percent in six months. Review of the current documented weights for Resident 104 revealed only one weight documented on June 4, 2026. The above information for Resident 104 was reviewed in a meeting with the Nursing Home Administrator and Employee 5, registered nurse, on July 23, 2026, at 2:00 PM. The facility provided no further weight documentation for Resident 104. A follow-up meeting with the Nursing Home Administrator on July 24, 2026, at 10:52 AM revealed the facility could provide no further documentation related to Resident 104's missing weights. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services		

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. Based on clinical record review and family and staff interview it was determined that the facility failed to assist a resident to replace lost glasses for one of two residents reviewed for vision/hearing concerns (Resident 14). Findings include: Interview with Resident 14's husband on July 21, 2026, at 12:54 PM revealed that Resident 14 wears glasses; however, she lost her glasses while living at the facility and staff cannot find them. Clinical record review for Resident 14 revealed that the facility admitted her on April 10, 2026. Resident 14's profile picture in her electronic medical record revealed that she wore glasses. A nursing admission progress note dated April 10, 2026, at 4:30 PM indicated that Resident 14 had glasses and that she was wearing a corrective vision appliance on admission. Review of available plans of care for Resident 14 since her admission to the facility failed to provide evidence that the facility incorporated Resident 14's use of glasses in her plan of care. Interview with the Nursing Home Administrator and the Director of Nursing on July 22, 2026, at 2:00 PM indicated that the facility had no knowledge or investigation of missing glasses for Resident 14. Observation of Resident 14 on July 22, 2026, at 11:26 AM; July 23, 2026, at 10:50 AM; and July 24, 2026, at 12:06 PM revealed her without glasses. Interview with the Nursing Home Administrator and Employee 5 on July 24, 2026, at 10:30 AM confirmed the above findings for Resident 14. The facility could not determine how soon after her admission to the facility that Resident 14 lost her glasses. The facility failed to include the use of glasses in Resident 14's plan of care and failed to implement timely measures to obtain replacement glasses when Resident 14's glasses were lost. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on clinical record review, observation, and staff interview, it was determined that the facility failed to provide the highest practical care to promote pressure ulcer healing for one of one resident reviewed for pressure ulcers (Resident 104). Findings include: Clinical record review for Resident 104 revealed social services documentation dated June 4, 2026, at 9:42 PM that noted the resident was admitted to the facility. Clinical record review for Resident 104 revealed a diagnoses list that included a displaced intertrochanteric fracture of the right femur (a type of broken hip). A Medicare 5-Day Minimum Data Set Assessment (MDS, an assessment completed at specific intervals to determine care needs) dated June 8, 2026, revealed that facility staff assessed Resident 104 as having a BIMS (Brief Interview for Mental Status) of 3, which indicated cognitive impairment. A skin and wound note dated June 5, 2026, at 2:36 PM noted the resident has two unstageable (severe full-thickness skin and tissue loss with undetermined depth) pressure ulcers present on admission which included one to the left sacrum (a bone in the lower back) and one to the coccyx (a bone at the base of the spine). The treatment recommendations from the medical provider for both wounds included cleanse with wound cleaner / normal saline; apply Santyl (a topical medication to promote healing of skin wounds) to the base of the wound; secure with superabsorbent; change daily. A physician order dated June 5, 2026, at 12:45 PM noted to cleanse the sacral wound with wound cleanser, pat dry with a 4x4 gauze pad and apply a layer of Santyl; cover with sacral opti-foam (a multi-layer wound covering) every dayshift for wound to sacrum. The order was discontinued on June 23, 2026. Review of the treatment administration record (TAR) for June 2026 for Resident 104 revealed that this treatment was not documented as completed per the medical provider's order on the following dates: June 6: no documentation on the TAR; blankJune 7: no documentation on the TAR; blankJune 19: no documentation on the TAR; blankJune 21: no documentation on the TAR; blankJune 23: no documentation on the TAR; blankA physician order dated June 4, 2026, at 2:55 PM noted a sacral dressing to coccyx every dayshift for healing/treatment; cleanse with wound cleanser; pat dry with 4x4 gauze and apply sacral opti. The order was discontinued on June 13, 2026. Review of the treatment administration record (TAR) for June 2026 for Resident 104 revealed that this treatment was not documented as completed per the medical provider's order on the following dates: June 6: no documentation on the TAR; blankJune 7: no documentation on the TAR; blankJune 13: no documentation on the TAR; blankFurther review of the TAR for Resident 104 for June 2026 and July 2026 revealed an order dated June 26, 2026, at 2:22 PM that noted to cleanse wound with Vashe wound cleanser; apply 0.125% Dakin's soaked gauze (a solution to cleanse wounds), gently pack into the undermining base of wound, secure with sacral superabsorbent , and change twice daily and as needed for wound on coccyx. This treatment was not documented as completed per the medical provider's order on the following dates: June 29 (3 PM - 11 PM shift): no documentation on the TAR; blankJune 30 (3 PM - 11 PM shift): no documentation on the TAR; blankJuly 7 (3 PM - 11 PM shift): no documentation on the TAR; blankJuly 16 (7 AM - 3 PM shift): no documentation on the TAR; blankJuly 20 (3 PM - 11 PM shift): no documentation on the TAR; blankFurther review of the TAR for Resident 104 for June 2026 revealed an order dated June 4, 2026, at 2:55 PM that noted a 4x4 opti-foam to mid spine every day shift every two days for protection/healing; cleanse wound with wound cleanse; pat dry with 4x4 gauze and apply 4 x4 opti-foam dressing. This was not documented as completed per the medical provider's order on the following dates: June 7: no documentation on the TAR; blankJune 19: no documentation on the TAR; blankJune 21: no documentation on the TAR; blankJune 23: no documentation on the TAR; blankThe above information for Resident 104 was (continued on next page)		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	reviewed in a meeting with the Nursing Home Administrator and Employee 5, registered nurse, on July 23, 2026, at 2:00 PM. The facility provided no further documentation that indicated the reason for the missing treatments (resident not available; treatments unavailable; resident refused, etc.) on the above dates for the orders that were active at the time. A follow-up interview with the Nursing Home Administrator on July 24, 2026, at 10:59 AM revealed the facility has no further documentation or reason that the above treatments were not documented as completed. 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 clinical record review, observation, and staff interview, it was determined that the facility failed to ensure an environment free from potential accident hazards for two of seven residents reviewed for accident hazards (Residents 5 and 14). Findings include: Observation of the nurses' station on July 22, 2026, at 9:42 AM revealed a device on the wall with a red flashing light with an audible hi-pitched alarm sounding. A computer screen below the flashing red light noted, Door Alarm, Common Smokers Patio, with the Age of the alarm at 27 minutes at that time. The alarm continued to sound with the visual signal until 9:47 AM without evidence that staff who were in the nurses' station at the time responded to the area indicated by the system to have a concern for a potentially unsecured exit door. Observation of the nurses' station on July 22, 2026, at 10:34 AM again revealed that the smoker's patio door was alarming by the visual and audible alarm. Observation of the smoker's patio from the common hallway on July 22, 2026, at 10:36 AM revealed a male resident sitting on his walker seat outside the glass door. Several staff walked through the area without responding to the door alarm or verifying the safety of the resident(s) outside the building. The surveyor began to exit the patio door and observed Employee 3 (activities director) sitting on the patio with a total of three residents. Employee 3 was not visible from the common hallway. Interview with Employee 3 on the date and time of the observation revealed that she had no way to turn off the door alarm (via a white button on the box mounted on the door that she cannot access once she takes residents through the door) once she exited the building. Employee 3 stated that staff are to respond once the alarm activates (by the opening of the patio door) to turn off the alarm. The alarm continued to sound without staff response on July 22, 2026, until 10:52 AM (sixteen additional minutes) when the three residents returned inside with Employee 3 and she discontinued the alarm. Two staff remained in the nurses' station and several employees walked through the common hallway and common dining room areas without checking for the safety of residents during the activation of an unsecured exit door alarm. Observation of the nurses' station on July 22, 2026, at 11:53 AM revealed that the smoker's patio door alarmed. Three staff were present at the nurses' station within the alarm's auditory and visual signals; however, no staff reported to the area to determine the cause of the alarm. The alarm continued to signal a potential security concern until 12:00 PM. Clinical record review of Resident 5's active physician orders revealed instructions for Resident 5 to have a Secure care (bracelet-type device meant to alarm should the device come in close proximity to an alarm box typically mounted at an exit door) on at all times, and staff are to check the placement and function of the device every shift. Review of a plan of care created by the facility on January 12, 2025, to address Resident 5's elopement risk and history of attempts to leave facility unattended revealed interventions that included a secure care device. Observation of Resident 5 on July 22, 2026, at 10:57 AM revealed her ambulating independently with her roller walker in and out of her room and in the hallways. Observation of Resident 5 on July 22, 2026, at 11:01 AM revealed her ambulating to the area near the smoker's patio exit door. Resident 5 sat in a chair in the area near the smoker's patio exit door. The smoker's patio exit door was not equipped with a secure care alarm box. Clinical record review for Resident 5 revealed nursing documentation dated April 4, 2026, at 11:37 AM that she had an unwitnessed fall outside the dining room (in the area near the exit door to the smoker's patio). Nursing documentation dated April 6, 2026, at 1:30 PM revealed that Resident 5 self-transfers and ambulates independently. Nursing documentation dated May 26, 2026, at 4:05 PM indicated that Resident 5 was exhibiting exit-seeking behavior. Social services documentation dated June 11, 2026, at 10:23 AM (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	noted that Resident 5 had cognitive impairment, poor adjustment to placement with times of agitation and confusion with poor safety awareness, was able to use a walker to move freely about the facility and exhibited daily wandering at will. Resident 5 had the potential to leave the facility unattended at all hours and had several documented exit-seeking behaviors since her last review. The interdisciplinary team discussed that Resident 5 had confusion and was often at the front entrance; and that the secure care device remained appropriate for safety. Nursing documentation dated June 13, 2026, at 10:30 AM noted that Resident 5 became increasingly agitated throughout the shift and wanted to leave the facility. Nursing documentation dated June 16, 2026, at 10:59 PM noted that Resident 5 was exit-seeking in the beginning of second shift. Nursing documentation dated June 19, 2026, at 2:06 PM noted that Resident 5 was continuously exit-seeking; and was walking back-and-forth. Nursing documentation dated June 26, 2026, at 9:24 PM noted that Resident 5 was exit-seeking and became verbally and physically aggressive when staff tried to redirect her (throwing her walker). Nursing documentation dated July 12, 2026, at 12:06 PM noted that Resident 5 was exit-seeking through the front entrance. The evidence above indicated that the lack of staff response to an alarm for an unsecured exit door posed a potential safety hazard for Resident 5. Clinical record review for Resident 14 revealed an admission MDS (Minimum Data Set, an assessment tool completed at specific intervals to determine resident care needs) dated April 15, 2026, that assessed her to have wandering behaviors that placed her at significant risk of getting to a potentially dangerous place (e.g., stairs, outside of the facility). Review of a plan of care created by the facility on April 13, 2026, to address Resident 14's elopement risk with potential for invasive behaviors and impaired safety awareness revealed a goal that Resident 14 would not leave the facility unattended. Interventions included in the plan of care identified that Resident 14 liked to sit outdoors and displayed recreational wandering. The interventions also included a secure care device that would be monitored for function per protocol. A plan of care developed by the facility to address Resident 14's risk for elopement created on April 13, 2026, included the goal that she would remain safe and secure within the facility and listed interventions that included staff would always be aware of her location. Observation of the nurses' station on July 23, 2026, at 10:22 AM revealed that the audible and visual alarm continued alerting a potential concern at the smoker's patio exit door until 10:25 AM while staff remained in the nurses' station. The surveyor requested that the staff at the nurses' station call the maintenance director on July 23, 2026, at 10:37 AM (while the smoker's patio door alarm continued). Employee 2 (maintenance director) arrived at the nurses' station on July 23, 2026, at 10:40 AM and confirmed that the audible and visual alarm at the nurses' station was for the exit door to the smoking area patio. Observation of the door with Employee 2 on July 23, 2026, at 10:40 AM confirmed that the door is never hard locked and that the door led to an outside patio and yard area that was secured with a locked gate. Employee 2 stated that only certain staff (maintenance, activities, and nursing supervisor on second shift) would have the key to disengage the alarm on the door. If that alarm is disengaged, staff would hear an alarm at the nurses' station only (the one identified as not responded to by staff) when that door is opened. Interview with Employee 3 on the date and time of the observation with Employee 2 reiterated that staff are to check the door when she exits with residents (that causes the alarm at the nurses' station to alarm), press the button that she cannot reach from outside the door, and the alarm will cease to continue the audible and visual alarm at the nurses' station. Observation of Resident 14 on July 23, 2026, at 10:50 AM revealed her independently self-propelling her wheelchair in the vicinity of the smoker's patio exit door. Observation of Resident 14 on July 24, 2026, at 12:06 PM revealed her to be self-propelling her wheelchair by the smoker's patio exit door. The evidence above indicated that the lack of staff response to an alarm for an (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	unsecured exit door posed a potential safety hazard for Resident 14. The surveyor reviewed the above safety concerns during an interview with the Nursing Home Administrator and Employee 5 (registered nurse) on July 23, 2026, at 2:00 PM. 483.25(d)(1)(2) Free of Accident Hazards/supervision/devicesPreviously cited deficiency 8/8/25 28 Pa. Code 201.18(b)(1)(e)(1) Management 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services		

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. Based on review of select facility policies and procedures, clinical record review, observation, and resident and staff interview, it was determined that the facility failed to implement care consistent with professional standards of practice to prevent potential complications from a dialysis access site for one of one resident reviewed for dialysis concerns (Resident 117). Findings include: Review of the facility's current procedure entitled Disconnecting PD (peritoneal dialysis) includes step by step directions for the procedure after completion of Resident 117's peritoneal dialysis (a treatment that uses the lining of your belly to filter blood when kidneys fail, accessed through a port located directly through the abdominal wall and connected to external tubing, also referred to as PD). This order of events in this document state that the resident's door should closed, staff should apply a mask, and then wash hands and apply gloves, prior to accessing the PD port. Observations on July 23, 2026, at 8:10 AM of Resident 117's disconnecting PD procedure, revealed that Employee 6, registered nurse, without performing any hand hygiene, placed gloves on before entering Resident 117's room. Employee 6 then entered the resident's room without closing the door and then applied a mask located in the resident's bedside table. Employee 6 continued to complete the procedure with the same gloves. Further review of facility documentation revealed that Employee 6 had not received any training from the facility related to Resident 117's PD. The above information was reviewed with the Nursing Home administrator and Employee 5, registered nurse, on July 23, 2026, at 2:30 PM. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services		

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of select facility policies and procedures, clinical record review, observation, and resident and staff interview, it was determined that the facility failed to assess all potential risk areas for entrapment for two of seven residents with enabler bars for accident hazards (Residents 86 and 99); and obtain informed consent for use of enabler bars for one of seven residents reviewed for accident hazards (Resident 86). Findings include: Clinical record review for Resident 99 revealed a diagnosis list that included difficulty in walking and muscle weakness. A quarterly Minimum Data Set Assessment (MDS, an assessment completed at specific intervals to determine care needs) dated June 28, 2026, revealed that facility staff assessed Resident 99 as having a BIMS (Brief Interview for Mental Status) of 15, which indicated no cognitive impairment. Review of the care plan for Resident 99 revealed the resident is at risk for falls related to difficulty in walking. An intervention included: requires the use of assist rails while in bed to enable to turn and reposition and assist staff with turning and repositioning. Further review of the care plan for Resident 99 revealed the resident has an ADL (activities of daily living) self-care performance deficit related to muscle weakness and difficulty in walking. An intervention included bilateral grab bars to bed to aid in independence and bed mobility. Observation and concurrent interview with Resident 99 on July 22, 2026, at 11:17 AM revealed bilateral enabler bars attached to the resident's bed. The resident reported he uses the enabler bars to help position. A request by the surveyor for documentation (evidence of informed consent, entrapment zone measurements, and any risk assessments) related to Resident 99's enabler bars was made to the facility during a meeting with the Nursing Home Administrator and Employee 5, registered nurse, on July 23, 2026, at 2:00 PM. The facility provided documentation titled, Nursing Acknowledgement of Physical Device - V2, dated January 17, 2025, at 1:28 PM. However, this document did not contain any entrapment zone measurements. A follow-up meeting with the Nursing Home Administrator on July 24, 2026, at 10:57 AM revealed that the facility could provide no further documentation to indicate the potential entrapment zones were assessed for Resident 99's enabler bars. Clinical record review for Resident 86 revealed a diagnosis list that included repeated falls. A quarterly Minimum Data Set assessment dated [DATE], revealed that facility staff assessed Resident 86 as having a BIMS of 14, which indicated no cognitive impairment. Review of the care plan for Resident 86 revealed the resident has an ADL self-care performance deficit related to generalized weakness. An intervention included grab bars on the bed to enable to assist with bed mobility. Observation and concurrent interview with Resident 86 on July 22, 2026, at 10:33 AM revealed bilateral enabler bars on the resident's bed. The resident reported she uses the enabler bars to get in and out of bed. A request by the surveyor for documentation (evidence of informed consent, entrapment zone measurements, and any risk assessments) related to Resident 86's enabler bars was made to the facility during meetings on July 22, 2026, at 2:00 PM and July 23, 2026, at 2:00 PM. The facility provided documentation for Resident 86 titled, Nursing Physical Device Review - V6, dated March 23, 2026, at 6:16 PM. However, this document did not contain any entrapment zone measurements or documentation of informed consent related to the enabler bars. A follow-up meeting with the Nursing Home Administrator on July 24, 2026, at 10:57 AM revealed that the facility could provide no further documentation to indicate the potential entrapment zones were assessed or informed consent was obtained for Resident 86's enabler bars. 28 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 on observation and staff interview, it was determined that the facility failed to properly store resident medications on one of three nursing units reviewed (Nursing Unit B). Findings include: Observation on July 23, 2026, at 9:16 AM during the medication pass on the Nursing Unit B revealed a medication cart being utilized by Employee 4, licensed practical nurse. Further observation of the medication cart revealed the following: There were several unsecured and unidentified medications found in the bottom of the drawers where medication blister cards were stored that included the following: two oblong yellow tablets, a round beige pill, half of an oblong shaped tablet, an oblong green colored tablet, a white round pill, and a smaller white round pill. The above findings were reviewed in a meeting with the Nursing Home Administrator and Employee 5, registered nurse, during a meeting on July 23, 2026, at 2:00 PM. 28 Pa. Code 201.18(b)(1) Management 28 Pa. Code 211.12(d)(1) Nursing services		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on observations, clinical record review, and staff interview, it was determined that the facility failed to ensure complete and accurate clinical documentation for one of 22 residents reviewed (Resident 117). Findings include: The surveyor made an observation on July 23, 2026, at 8:10 AM of Employee 6, registered nurse, complete the disconnection procedure for Resident 117 after completion of their peritoneal dialysis treatment (a treatment to complete dialysis in a home setting that uses the lining of your belly to filter blood when kidneys fail, accessed through a port located directly through the abdominal wall and connected to external tubing which is run through a filtration machine, also referred to as PD). Review of Resident 117's clinical record revealed that the nurse who initialed (documented) completing this procedure was Employee 4, licensed practical nurse. Further review revealed that there was no documented completion for this task on three additional dates in July of 2026, including July 15, 16, and 18. Additionally, there was no documentation on the resident's treatment record indicating who initiated their PD on July 19, 20, and 21 of 2026. This information was reviewed with the Nursing Home Administrator and Employee 5, registered nurse, on July 23, 2026, at 2:30 PM. 28 Pa. Code 211.5(i) Medical records 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395699	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/24/2026
NAME OF PROVIDER OR SUPPLIER Sweden Valley Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0814 Level of Harm - Potential for minimal harm Residents Affected - Many	Dispose of garbage and refuse properly. Based on observations and staff interview, it was determined that the facility failed to properly contain and dispose of garbage at the facility's outside dumpsters. Findings include: Observation of the facility's main dumpsters located outside on facility property on July 21, 2026, at 10:30 AM, revealed the following: A dumpster which Employee 15, dietary supervisor, indicated is used for recyclable products with its lid open. Next to two additional dumpsters in the same area were several broken wheelchairs, miscellaneous equipment parts, five wooden pallets, and one broken lawn chair. A second observation of the area on July 22, 2026, at 10:26 AM, revealed metal framing for a pop-up tent, had been added to the pile of broken wheelchairs and parts and other items noted above and the following: A piece of paper with resident identifying name and room number, laying in the grass next to the two dumpsters, near the pile of broken items. On the ground surrounding a single dumpster was various debris consisting of plastic lids, leaves, an empty crushed nutritional container, cigarette butts, three medical gloves, plastic silverware, and a plastic paint tray. A follow up observation on July 24, 2026, at 9:05 AM, revealed the debris around the single dumpster remained with a wooden pallet, and the paper with the resident name and room number remained in the grass. The above information was reviewed in a meeting with the Nursing Home Administrator and Employee 5 on July 24, 2026, at 10:40 AM. 28 Pa. Code 201.14(a) Responsibility of licensee		