STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395779	A. Building B. Wing	08/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Centre Care Rehabilitation and Wellness Services	250 Persia Road Bellefonte, PA 16823

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on review of facility documentation, clinical record review, and staff interview, it was determined that the facility failed to ensure a complete and thorough investigation of an injury of unknown origin for one of one resident reviewed. (Resident 152) Findings include:Clinical record review for Resident 152 revealed a progress note dated June 27, 2025, that indicated staff observed a 5 centimeter (cm) by 4 cm purple bruise to the top of Resident 152's right breast. The progress note indicated that Resident 152 was known to transfer self from chair to bed and toilet and that she was also known to wander with poor safety awareness. Review of the facility's investigation report dated June 27, 2025, at 8:00 AM revealed that Resident 152 was observed with a 5cm x 4cm purple bruise to the top of her right breast. The report also indicated that Resident 152 was unable to give a description of what occurred. The report indicated that the immediate action taken was to assess and measure the area. The report also indicated that Resident 152 was known to transfer self from chair to bed and toilet. She is a known wanderer with poor safety awareness, and she always has multiple things in her hands holding them against her body. The facility's investigation report also had a note dated June 27, 2025, that indicated an interdisciplinary team reviewed the incident and after the investigation it was noted that Resident 152 carries multiple things on her lap and chest while propelling herself up and down the hallways and throughout the building. Many times, she has two large pitchers of drinks with her rested on her chest. The report indicated that the area on her chest was consistent with carrying the two large pitchers of drinks with her and that abuse was ruled out. Further review of the facility's investigation into Resident 152's bruise on her right upper breast revealed two staff witness statements. The first statement was from a nurse aide dated June 27, 2025, that indicated she had Resident 152 on the toilet and Resident 152 pulled her collar down to show her the bruise located on the top of her right breast. The statement indicated Resident 152 was aware of the bruise but did not know how it occurred. The second statement was dated June 27, 2025, and was from a licensed practical nurse, and she indicated that she was made aware of the bruise by the registered nurse on duty and that Resident 152 did not know how the bruise occurred. Interview with the Director of Nursing on August 15, 2025, at 11:25 AM revealed that investigations of injuries of unknow origin require that the facility obtain statements from any staff assigned to the resident and any other staff who provided care or have direct knowledge of the incident on the three shifts prior to discovery unless a cause is identified during the interview process. She confirmed at this time that she only had the two statements provided to the surveyor and no further investigation was completed. The facility failed to thoroughly investigate Resident 152's injury of unknown origin to determine the cause and rule out abuse. 28 Pa. Code 201.14(a)(c) Responsibility of licensee 28 Pa. Code 201.18(b)(2)(e)(1) Management

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395779	A. Building B. Wing	08/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Centre Care Rehabilitation and Wellness Services	250 Persia Road Bellefonte, PA 16823

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. Based on clinical record review and staff interview, it was determined that the facility failed to ensure complete and accurate Minimum Data Set (MDS) assessments for one of 35 residents reviewed (Resident 13). Findings include: Clinical record review of Resident 13's current physician orders revealed an order for Nuplazid (an antipsychotic medication used to treat hallucinations associated with Parkinson's disease) oral cap 34 mg (milligrams) po (by mouth) at bedtime that was ordered November 13, 2021. Review of Resident 13's clinical record revealed quarterly Minimum Data Set Assessments (MDS, a form completed at specific intervals to determine care needs) dated March 11, 2025, and June 10, 2025, that failed to indicate Resident 13 was taking an antipsychotic medication. Interview with the Director of Nursing and Nursing Home Administrator on August 14, 2025, at 1:45 PM confirmed the above noted information that the facility failed to accurately code Resident 13's MDS assessments dated March 11, 2025, and June 10, 2025. 483.20(g) Accuracy of AssessmentsPreviously cited 10/8/2024 28 Pa. Code 211.5(f)(ix) Medical records 28 Pa. Code 211.12(d)(1)(5) Nursing services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395779	A. Building B. Wing	08/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Centre Care Rehabilitation and Wellness Services	250 Persia Road Bellefonte, PA 16823

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. Based on clinical record review and staff and resident interview, it was determined that the facility failed to ensure the highest practicable care for a change in condition for one of 35 residents reviewed (Resident 228). Findings include: In an interview with Resident 228 on August 12, 2025, at 12:10 PM the resident indicated although she was primarily independent with activities of daily living (walking, dressing, toileting, hygiene), she has been declining over the past several months with worsening recently due to having pneumonia (lung infection) and a recent appendectomy (procedure to remove an appendix). Resident 228 indicated she felt since staff knew she was independent in the past they don't offer more help, and it has all been harder for her lately. A family member of Resident 228's indicated they were purchasing an electronic scooter for the resident so she could get around easier. Resident 228 stated she was not receiving therapy nor has therapy assessed her with her recent decline. The family member indicated the purchase of a scooter was the family's decision and did not come from therapy. Clinical record review for Resident 228 revealed the resident did have two recent hospital admissions from June 23 to 28, 2025, and July 30 to 31, 2025, for pneumonia and the appendectomy. Review of a re-admission Nursing Evaluation dated July 31, 2025, revealed Resident 228 was assessed as independent with activities of daily living such as bed mobility, eating, transfers, toileting, dressing, and ambulation, upon return to the facility from the hospital on that date. Further clinical record review revealed a Rehabilitation Referral for Resident 228 dated August 5, 2025, that indicated the referral was requested due to the resident's re-admission and a change in functional status due to recent hospitalization. This referral was not signed off and locked in the electronic record system until August 14, 2025, at 6:34 PM, after the resident's and therapy concerns were brought to facility administration's attention on August 13, 2025, at 2:00 PM by the surveyor. There was no evidence to indicate therapy (physical therapy/occupational therapy) completed an assessment of the resident for the potential decline until August 14, 2025, nine days after the referral was initiated in the electronic record system. Review of a physical therapy evaluation and plan of treatment completed for Resident 228 dated August 14, 2025, revealed the resident presented a decline from her prior level of function as the resident required supervision or touching assistance to stand from sitting, required contact guard for transfers, and the resident's gait (walking) assessment was not attempted due to medical/safety concerns. The assessment indicated the resident was independent with these tasks as her prior level of function. Interview with the Director of Nursing on August 15, 2025, at 12:20 PM confirmed Resident 228 was not evaluated by therapy staff until August 14, 2025, when a rehab referral was paperwork was initiated on August 5, 2025, by nursing staff but not completed. 483.25 Quality of CarePreviously cited deficiency 10/8/24 28 Pa. Code 211.10(c) Resident care policies 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395779	A. Building B. Wing	08/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Centre Care Rehabilitation and Wellness Services	250 Persia Road Bellefonte, PA 16823

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 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 review of select policy and procedures, clinical record review, and staff interview, it was determined that the facility failed to provide timely assessments and implement interventions to promote acceptable parameters of nutritional status for one of seven residents reviewed for nutritional concerns (Resident 7). Findings include: The facility policy entitled Weighing of Residents, last reviewed without changes June 1, 2025, revealed the facility will monitor the resident's weight to detect significant weight loss or gain in order to ensure that the resident maintains acceptable parameters of nutritional status, taking into account the resident's clinical condition or other appropriate interventions, when there is a nutritional problem. If a resident exhibits a weight change of five pounds from the previous weight in a monthly report, the resident will be reweighed within 24 hours and the reweight will be recorded. If the weight is validated as a new greater than five percent change in one month, the resident will be reviewed by the registered dietitian to investigate the cause of the weight change and to determine if interventions are necessary. If the weight change falls into the significant category the registered dietician will complete a timely assessment to investigate to investigate the cause of the weight change. The registered dietician will notify the charge nurse, doctor, family, and registered nurse assessment coordinator of significant weight changes. Clinical record review revealed the facility admitted Resident 7 on January 21, 2023. Further review of Resident 7's clinical record revealed the following weight assessments: December 4, 2025, 220.6 poundsJanuary 8, 2025, 205.6 pounds (a 15-pound, 6.79 percent significant weight loss in 30 days)February 4, 2025, 207 pounds There was no evidence that staff obtained a re-weight or notified Resident 7's physician after the January 2025 significant weight loss. Further review of Resident 7's clinical record revealed no assessment of Resident 7's significant weight loss, or any interventions addressing the significant weight loss. Interview with the Nursing Home Administrator on August 15, 2025, at 11:00 AM confirmed these findings. The Nursing Home Administrator stated that registered dietitian is no longer employed by the facility. 28 Pa. Code 211. 10(d) Resident care policies 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395779	A. Building B. Wing	08/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Centre Care Rehabilitation and Wellness Services	250 Persia Road Bellefonte, PA 16823

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 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 clinical record review, observation, and staff and resident interview, it was determined that the facility failed to obtain informed consent for use of side rails/enabler bars for two of three residents reviewed (Residents 40 and 176); and failed to assess the entrapment risk associated with the use of side rails/enabler bars for two of three residents reviewed (Residents 40 and 149). Findings include: Clinical record review for Resident 40 revealed a diagnosis list that included weakness, generalized muscle weakness, and difficulty in walking. Observation of Resident 40 on August 12, 2025, at 11:19 AM revealed the resident was in bed. There was a side rail attached to the resident's right side of the bed. A concurrent interview with Resident 40 revealed the resident utilizes the side rail to help get around. Clinical record review for Resident 40 revealed no evidence that the facility obtained informed consent or assessed the side rail for entrapment risks. An interview with the Nursing Home Administrator on August 15, 2025, at 10:06 AM confirmed there was no informed consent or assessment of entrapment zones for Resident 40. An interview with the Director of Nursing on August 15, 2025, at 11:31 AM revealed that it was determined that Resident 40's family brought the side rail into the facility and attached it to the resident's bed at an unknown date after Resident 40's admission to the facility. Clinical record review for Resident 176 revealed a diagnosis list that included generalized muscle weakness, and abnormalities of gait and mobility. Observation of Resident 176 on August 13, 2025, at 11:45 AM revealed the resident was sitting upright on the side of the bed. An enabler bar was observed attached to the resident's left side of the bed. The other side of the bed was against the wall. A concurrent interview with Resident 176 revealed he utilized the bar to help position. Clinical record review for Resident 176 revealed no evidence that the facility obtained informed consent for the use of the side rails/enabler bars. An assessment for Resident 176 titled, Bed Safety with Measuring Tool, dated June 9, 2025, noted staff documented yes to the question, Signed Consent explaining risk versus benefit in place for use of the siderail/enabler? However, there was no evidence of this document in the clinical record. An interview with the Director of Nursing on August 15, 2025, at 11:47 AM revealed the facility could provide no further documentation of informed consent related to enabler bars for Resident 176. In an interview and observation of Resident 149 on August 13, 2025, at 11:11 AM enabler bars (grab bars) were observed on both sides of the resident's bed. Resident 149 indicated the bars help her to move in bed. Clinical record review for Resident 149 revealed facility staff last assessed Resident 149's bed safety on June 9, 2025. Review of a Bed Safety with Measuring Tool assessment dated [DATE], for Resident 149 revealed the resident was noted to have bilateral (both sides) enabler bars on her bed. The assessment noted bed safety measurements were completed to assure there was no risk of entrapment (head/neck/chest getting stuck) for areas including Zone 1, within the rail' Zone 2, under the rail between the rail supports; Zone 3, between the rail and the mattress; and Zone 4, under the rail and the ends of the rail. Zone 6, the area between the end of the rail and the side edge of the head or footboard, was listed on the assessment but was not completed to indicate if the enabler bars passed or failed the safety assessment for the resident for this area. Further clinical record review for Resident 149 revealed the resident also had Bed Safety with Measuring Tool assessments completed on January 5, 2024, (the date the enablers were initiated), March 7, 2024, June 30, 2024, September 9, 2024, December 30, 2024, and March 7, 2025, with the Zone 6 assessment area not completed. The above results were reviewed during an interview with the Nursing Home Administrator on August 15, 2025, at 10:15 AM. 28 Pa. Code 211.10(d) Resident care policies 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services