

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: 395779	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/31/2026
NAME OF PROVIDER OR SUPPLIER Centre Care Rehabilitation and Wellness Services		STREET ADDRESS, CITY, STATE, ZIP CODE 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 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 review of select facility policies and procedures, observation, and staff interview, it was determined that the facility failed to store and prepare food items in a safe and sanitary manner and maintain equipment in a sanitary condition, in the main kitchen of the facility and one of five nursing units (Mills Nursing Unit Kitchenette). Findings include: Initial tour of the facility's main kitchen with Employee 10, Director of Dining Services, on July 28, 2026, at 9:32 AM revealed the following: The dry goods storage area contained two boxes of mustard. An opened box of mustard that contained several containers of mustard noted a best if used by date of March 4, 2026, and another unopened box had a best if used by date of May 9, 2026. A container of ground cloves had a best by date of July 20, 2025. A pair of red oven mitts on a stainless-steel shelf in front of the oven were torn with the underpadding showing. There was an accumulation of debris on top of the oven that included dust, two frayed white colored potholders, and pieces of unidentified burnt debris. Two basins on the bottom shelf of a storage shelf held plastic lids (one basin had blue lids and the other basin contained red and green lids) had an accumulation of debris in the bottom of the basins. Observation of the dish machine and a concurrent interview with Employee 10 revealed the dish machine was a hot-water sanitizing machine. There were two temperature gauges visible. The temperature gauge on the right, which was the rinse temperature gauge per Employee 10, appeared to have a bent dial plate, debris in the bottom of the gauge, and an accumulation of moisture inside of the gauge. Observation of two dish machine cycles revealed that the rinse gauge was difficult to read due to the condition of the gauge. Review of facility documentation titled, Main Kitchen Dish Machine Water Temperature Monitor, for July 2026 noted on the document routine ware washing standards of a wash temperature of 160 degrees Fahrenheit or higher; final / freshwater rinse of 180 degrees Fahrenheit or higher. The document noted instructions for staff to please notify the supervisor immediately if water temperatures are not reaching acceptable standards. The temperatures of the dish machine documented by staff for July 2026 revealed the following which were below the temperature stipulated for the final rinse: July 2, 2026 (afternoon): 178 degrees. No corrective action documented. July 12, 2026 (morning): 179 degrees. No corrective action documented. July 20, 2026 (afternoon): 172 degrees. No corrective action documented. July 21, 2026 (afternoon): 174 degrees. No corrective action documented. July 22, 2026 (afternoon): 174 degrees. No corrective action documented. July 23, 2026 (morning): 178 degrees. No corrective action documented. July 26, 2026 (morning): 172 degrees. No corrective action documented. July 26, 2026 (afternoon): 175 degrees. No corrective action documented. The above information was reviewed in a meeting with the Director of Nursing and Employee 12, Assistant Nursing Home Administrator, on July 29, 2026, at 1:45 PM. The facility policy titled, Refrigerator and Frozen Food Storage, revealed a section titled, Refrigeration, that noted (in part) that refrigerator temperature will be maintained at or below 41 degrees Fahrenheit. Facility documentation titled, (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	Production Kitchen Equipment Temp Monitor, for July 2026 revealed that staff were documenting on Cooler number six. Review of this documentation revealed that staff documented a temperature greater than 41 degrees on the following dates: July 1, 2026: morning (42 degrees); afternoon (43 degrees).July 2, 2026: morning (43 degrees); afternoon (43 degrees).July 3, 2026: afternoon (43 degrees).July 5, 2026: afternoon (42 degrees).July 6, 2026: morning (42 degrees).July 7, 2026: morning (43 degrees).July 8, 2026: afternoon (43 degrees).July 9, 2026: morning (44 degrees); afternoon (42 degrees).July 10, 2026: morning (42 degrees); afternoon (42 degrees).July 11, 2026: morning (43 degrees).July 12, 2026: morning (42 degrees).July 13, 2026: afternoon (42 degrees).July 14, 2026: afternoon (43 degrees).July 15, 2026: morning (43 degrees); afternoon (42 degrees).July 16, 2026: morning (42 degrees).July 17, 2026: morning (43 degrees).July 18, 2026: morning (42 degrees); afternoon (42 degrees).July 20, 2026: afternoon (42 degrees).July 21, 2026: afternoon (42 degrees).July 22, 2026: morning (42 degrees); afternoon (43 degrees).July 24, 2026: morning (42 degrees).July 25, 2026: morning (42 degrees).July 26, 2026: morning (43 degrees).July 27, 2026: afternoon (43 degrees).July 28, 2026: morning (42 degrees). An interview with Employee 10 on July 29, 2026, at 2:20 PM confirmed that the temperature should be at or below 41 degrees for the refrigeration. Any temperatures outside of this range, maintenance is notified. Review of the prepared food temperatures for the main kitchen for July 2026 revealed the temperature documentation was kept in a binder. The following dates for documented prepared food temperatures were missing: July 13, 2026: breakfast and lunch were missing.July 15, 2026: breakfast, lunch, supper missing. Observation of the Mills Nursing Unit on July 30, 2026, at 12:10 PM revealed a meal temperature documentation binder titled, Food Temp Log C2. The following dates for documented food temperatures were missing: July 2, 2026: breakfast and supper missingJuly 4, 2026: breakfast, lunch, and supper missingJuly 5, 2026: breakfast, lunch, and supper missingJuly 8, 2026: breakfast missingJuly 9, 2026: lunch missingJuly 11, 2026: breakfast, lunch, and supper missingJuly 12, 2026: breakfast, lunch, and supper missingJuly 18, 2026: breakfast, lunch, and supper missingJuly 19, 2026: breakfast, lunch, and supper missingJuly 23, 2026: supper missing.July 24, 2026: lunch missing.July 25, 2026: breakfast, lunch, and supper missingJuly 26, 2026: breakfast, lunch, and supper missing There was no evidence to indicate the food served at the above dates and meals was prepared/served at appropriate temperatures. The above information for the temperatures was reviewed in a meeting with the Nursing Home Administrator on July 30, 2026, at 1:45 PM. A follow-up meeting with the Nursing Home Administrator on July 31, 2026, at 1:24 PM revealed that the facility could provide no further documentation related to the missing food temperatures or out of range temperatures for Cooler #6. 28 Pa. Code 201.14(a) Responsibility of licensee		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, observation, and resident, staff, and family interview, it was determined that the facility failed to provide dependent residents timely assistance with activities of daily living for four of five residents reviewed for activities of daily living concerns (Residents 11, 52, 157 and 177). Findings include: Clinical record review for Resident 52 revealed quarterly MDS (Minimum Data Set, an assessment tool completed at specific intervals to determine resident care needs) assessments dated March 11, 2026, and June 9, 2026, that assessed her as dependent for eating, toileting, bed mobility, showers/bathing, personal hygiene, and transfers. Observation of Resident 52 on July 30, 2026, at 10:28 AM revealed her in bed without her helmet (soft helmet device worn to protect the head) on her head. Her helmet was on her bedside stand. Interview with Employee 2 (nurse aide assigned to the third-floor hallway where Resident 52 resided) on July 30, 2026, at 10:33 AM revealed that she had not provided any care for Resident 52 on this date. Employee 2 stated that Employee 6 (registered nurse assessment coordinator) came from the second floor to feed Resident 52 breakfast, but Employee 2 was unsure if she attempted to put Resident 52's helmet on or if she provided Resident 52 any other care that morning (e.g., morning hygiene, incontinence care, etc.). Employee 2 stated that Employees 3 (nurse aide), 4 (registered nurse), and 5 (licensed practical nurse), were the other staff assigned to the hallway where Resident 52 resided on this date. Interview with Employee 3 on July 30, 2026, at 10:36 AM revealed that she denied providing any care to Resident 52 on this date. Interview with Employees 4 and 5 on July 30, 2026, at 10:37 AM revealed that neither one provided any care for Resident 52 on this date. Interview with Employee 6 on July 30, 2026, at 1:03 PM confirmed that she fed Resident 52 her breakfast that morning, however, she did not perform any other activities of daily living assistance (e.g., incontinence care, morning hygiene, etc.). Review of July 2026 Documentation Survey Report (electronic form used by the facility for the documentation of completion of activities of daily living) data as of July 30, 2026, at 3:09 PM revealed that no staff documented any assistance for Resident 52 with bed mobility, bowel and bladder incontinence management, (e.g., check and change per facility protocol), dressing, eating, hygiene, restorative nursing range of motion exercises, personal hygiene, positioning devices (e.g., heel boots), oral care (e.g., dentures), or transfer with a mechanical lift for July 29 or 30, 2026. The surveyor reviewed the above concerns regarding the omission of care for Resident 52 during an interview with the Nursing Home Administrator and Employee 1 (assistant director of nursing) on July 30, 2026, at 1:45 PM, and with the Nursing Home Administrator on July 31, 2026, at 9:00 AM. Clinical record review for Resident 11 (who resided on the third-floor nursing unit) revealed a quarterly MDS dated [DATE], that assessed Resident 11 as dependent upon staff for toileting, bed mobility, and personal hygiene. Observation of the third-floor nursing unit on July 29, 2026, at 10:03 AM revealed Resident 11 yelling from her bed, nurse please bring the bed pan. Resident 11's call bell was not activated at the time of the observation. Observation on July 29, 2026, at 10:05 AM revealed an unidentified staff person entered Resident 11's room and directed her to activate her call bell for assistance. Observation of the third-floor nursing unit call bell system monitor on July 29, 2026, at 10:05 AM revealed the call bell for Resident 11's bed assignment activated. Resident 11 was heard yelling, nurse, I need the bedpan, from the hallway. Continued observation of the third-floor nursing unit on July 29, 2026, at 10:06 AM revealed Resident 11 yelled, very badly, while her call bell was activated. Continued observation of the third-floor nursing unit on July 29, 2026, at 10:11 AM revealed Resident 11 yelled, I need the bed pan, while her call bell was activated. Continued observation of the third-floor nursing unit on July 29, (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2026, at 10:18 AM revealed Resident 11 yelled, nurse, I need a bedpan, while her call bell was activated. An unidentified staff member entered Resident 11's room on July 29, 2026, at 10:19 AM and turned off Resident 11's call bell (the call bell system monitor panel no longer indicated that Resident 11 had her call bell on); however, on July 29, 2026, at 10:22 AM Resident 11 continued to yell, nurse, I need a bedpan. Continued observation of the third-floor nursing unit on July 29, 2026, at 10:24 AM revealed Resident 11 again yelled, nurse, I need a bedpan, please hurry. The surveyor entered Resident 11's room on July 29, 2026, at 10:26 AM to find Resident 11 in bed, holding her call bell. Resident 11 stated, I already started (having a bowel movement), can you go see them or something? The surveyor requested Resident 11 activate her call bell; to which Resident 11 stated, I've been calling for a little while. Resident 11 pressed her call bell at that time. On July 29, 2026, at 10:31 AM, Employee 7 (nurse aide) entered Resident 11's room. When Resident 11 told Employee 7 that she needed the bedpan and the surveyor informed Employee 7 that Resident 11 had been calling for a bedpan and reported that she had started having a bowel movement, Employee 7 stated, she's incontinent. Resident 11 repeated, I've already started a bowel movement. Without explanation, Employee 7 left Resident 11's room and did not return until July 29, 2026, at 10:34 AM carrying linens. Resident 11 stated, I'm really hurting here, I started making the bowel movement 20 minutes ago, can you please hurry? Employee 7 put a new garbage bag in Resident 11's bedside garbage receptacle, retrieved clothing from Resident 11's closet, and started running water in Resident 11's bathroom. Resident 11 stated, the stool has started. Continued observation on July 29, 2026, at 10:37 AM revealed Employee 7 began to start washing Resident 11's face and Resident 11 stated, my rectum is halfway open; to which Employee 7 asked Resident 11 if she was going to get out of bed this day and into her chair. Continued observation on July 29, 2026, at 10:39 AM revealed Employee 7 removed Resident 11's gown and washed Resident 11's hands at which time Resident 11 stated, concentrate on getting me cleaned up. Observation on July 29, 2026, at 10:41 AM revealed Employee 7 rolled Resident 11 onto her left side and stool was noted protruding from Resident 11's rectum. Employee 7 did not have a bedpan to place under Resident 11. Once Employee 7 began pressing on Resident 11's buttocks, a very large amount of soft, brown, stool evacuated from Resident 11's rectum. After no further stool evacuated from Resident 11's rectum, Employee 7 asked Resident 11 if she wanted the bedpan to which Resident 11 stated, no not now, just get me cleaned off. The facility failed to meet Resident 11's need for a bedpan timely as evidenced above. The surveyor reviewed the above observations of Resident 11 during an interview with Employee 12 (assistant nursing home administrator) and the Director of Nursing on July 29, 2026, at 1:45 PM. Clinical record review for Resident 157 revealed an annual MDS assessment dated [DATE], that staff assessed him as needing substantial/maximal staff assistance with toileting hygiene. Observation of the facility's call bell system monitor on July 28, 2026, at 2:01 PM revealed that Resident 157's toilet pull cord bell was activated on July 28, 2026, at 2:01 PM for 25 minutes. The signal for Resident 157's toilet pull cord call bell signal discontinued on July 28, 2026, at 2:05 PM (indicating that staff responded to his call bell approximately 30 minutes after he activated it in his bathroom). During an interview with Resident 157 on July 28, 2026, at 3:11 PM Resident 157 stated that the facility does not have enough help, that he rings the call bell, but it does not result in staff coming to help him timely. Resident 157 stated that on two occasions on this date he activated his call bell and had to wait half an hour in the bathroom for someone to help him. Resident 157 stated that he was, having problems with (his) bowels right now. Resident 157 stated that when staff do not respond timely, he yells, at the top of (his) lungs and get(s) in trouble for yelling out when no one comes. Interview with Resident 157's wife (who was his roommate and present for the interview with Resident 157) confirmed that there are times that she (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	will go to try and find staff before he begins to yell out. Resident 157's wife confirmed that he waited a long time in the bathroom for staff assistance on this date. The surveyor reviewed the above concerns regarding Resident 157's call bell during an interview with Employee 12 and the Director of Nursing on July 29, 2026, at 1:45 PM. Clinical record review for Resident 177 revealed a significant change MDS dated [DATE], that assessed her as dependent on staff assistance for toileting, bathing, dressing, personal hygiene, bed mobility, and chair-to-bed transfers. Interview with Resident 177 on July 29, 2026, at 9:45 AM revealed that call bell response times, can be a long time or a short time. Resident 177 stated that, A long time can be an hour, last week one night was a long one, they are so short-handed, not enough people to go around. Interview with Resident 177 and her son on July 30, 2026, at 10:58 AM revealed that on Friday night, July 24, 2026, Resident 177 waited for staff assistance for at least an hour. Resident 177's son stated that he brought Resident 177 back to her room from the dining room after her dinner meal and she was sitting in her wheelchair. Resident 177 was falling asleep in her chair and he believed that he had to stay, sat in front of her, propping her up because she was falling asleep in her wheelchair and (he) didn't want her to fall out. Resident 177 stated that he knew her call bell was activated because he saw the red light on the wall behind her bed. Resident 177's son stated that he stayed with her until staff came to transfer her to bed and he did not get to his home until approximately 7:45 PM. Resident 177's son was confident that her call bell had to have been activated from approximately 6:00 PM to 7:00 or 7:10 PM. Resident 177's son stated that while he waited, he went out into the hallway to ask staff to transfer Resident 177 back to bed but, they were putting everyone else in bed and did not get to her right away. They were working. Resident 177's son stated that he was going to ask someone in administration what the protocol was when, it is quite a while before someone shows up. Resident 177's son stated that he was going to, go away Friday night but (he) didn't because (he) was here so long. The surveyor reviewed the details reported by Resident 177 and her son during an interview with the Nursing Home Administrator and Employee 1 on July 30, 2026, at 1:45 PM. 28 Pa. Code 211.12(d)(1)(5) Nursing services		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. Based on clinical record review, resident observation, and staff interview, it was determined that the facility failed to provide the highest practicable care regarding physician-ordered assistive devices and failed to meet professional standards of practice for an abdominal binder for three of 35 residents reviewed (Residents 10, 13 and 17). Findings include: Clinical record review for Resident 17 revealed a physician order for a heels up device initiated on February 8, 2025, and an order for nonskid socks at all times except for care-initiated January 24, 2024. Observation of Resident 17 on July 28, 2026, at 12:03 PM, July 29, 2026, at 10:14 AM, and July 30, 2026, at 1:13 PM revealed Resident 17 did not have gripper socks on, or the heels up device in place. Interview with Resident 17 on July 30, 2026, at 1:13 PM confirmed that he has not worn the gripper socks in a long time and he does not utilize the heels up device. Review of Resident 17's Treatment Administration Record (a form utilized by facility to document the administration of treatments) dated July 2026, revealed nursing staff documented the heels up device and nonskid socks in place on July 28, 29, and 30, 2026. The surveyor reviewed the above findings for Resident 17 during an interview with the Nursing Home Administrator on July 31, 2026, at 9:18 AM. He confirmed the staff documented the physician ordered assistive devices were in place when the devices were not in place. Clinical record review for Resident 13 revealed a diagnosis list that included Adult Failure to Thrive (a condition in which an individual exhibits an overall decline in the ability to function) and Diabetes (a chronic health condition where blood sugar levels are too high) Type 2. Clinical record review for Resident 13 revealed a current physician order initiated on July 8, 2026, for house no sugar added (NSA) shake every day and evening shift for supplementation. Resident 13's current care plan (an outline of an individual's health needs, specific care requirements, and the actions necessary to achieve desired health outcomes) revealed the resident had a nutritional care plan related to Diabetes Type 2/cardiac impairment requiring therapeutic diets (specialized diet to help manage health conditions), and variable meal intakes requiring supplementation. An intervention included to provide and serve supplements as prescribed: NSA Health Shake. Review of Resident 13's medication administration record (MAR) from July 8, 2026, to July 28, 2026, revealed 10 occasions where nursing documented a 9 (chart code that means other/see Nurse notes) for the house shake. Review of the progress notes for the following revealed: July 9, 2026, at 8:16 AM: UnavailableJuly 9, 2026, at 4:38 PM: UnavailableJuly 10, 2026, at 9:05AM: UnavailableJuly 14, 2026, at 12:58 PM: UnavailableJuly 15, 2026, at 11:30 AM: UnavailableJuly 15, 2026, at 4:59 PM: UnavailableJuly 18, 2026, at 12:16 PM: UnavailableJuly 18, 2026, at 11:15 PM: Not availableJuly 19, 2026, at 8:55 PM: Not availableJuly 21, 2026, at 9:12 PM: Not available The above information was reviewed with the Nursing Home Administrator and Employee 1, Assistant Director of Nursing, on July 30, 2026, at 2:05 PM. Nursing Home Administrator verified on July 31, 2026, at 9:25 AM that the house shakes were available at the above times but were not provided to Resident 13. Observation of Resident 10 on July 29, 2026, at 8:45 AM revealed him lying in bed on his right side with a white abdominal binder (wide elastic compression belt) on. On July 29, 2026, at 8:47 AM Employee 20 (LPN) verified that Resident 10 is wearing an abdominal binder and has been wearing it prior to present time. Employee 20 reported that staff removes it when it is soiled, when care is being performed, and when nursing is working with his percutaneous endoscopic gastrostomy tube, PEG, (a medical device placed through the abdominal wall into the stomach to deliver nutrition, fluids, and medication). Employee 20 also reported that Resident 10 has a history of pulling on his PEG tube. Review of Resident 10's clinical record revealed no physician order for the abdominal binder or to check skin integrity related to the abdominal binder. Review of Resident 10's care plan revealed no (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	mention of the abdominal binder. Review of Resident 10's progress notes revealed a nursing progress note dated July 1, 2026, at 6:45 AM that included: Binder open and is saturated with BM. Also, a nursing progress note dated July 9, 2026, that included: Resident has been fussing with his PEG tube and abdominal binder. A physician progress noted dated July 24, 2026, revealed a Peg tube with binder overlying. The above information for resident 10 was reviewed in a meeting with the Nursing Home Administrator and Director of Nursing on July 29, 2026, at 2:20 PM. The Nursing Home Administrator confirmed the findings on July 30, 2026, at 2:10 PM. 483.25 Quality of CarePreviously cited 8/15/25. 28 Pa. Code 211.10(d) Resident care policies 28 Pa. Code 211.12(c)(d)(1)(3)(5) Nursing services		

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. Based on clinical record review, observation, and resident and staff interview, it was determined that the facility failed to ensure a medication error rate of less than five percent (Residents 121 and 136). Findings include: The facility's medication error rate was 6.25 percent based on 32 medication opportunities with two medication errors. Observation for Resident 121 of a medication administration pass on July 30, 2026, at 9:03 AM revealed that Employee 11, licensed practical nurse, administered a Slow Magnesium/Calcium Oral Tablet (a dietary supplement that combines magnesium and calcium) 70-117MG (milligrams). Clinical record review for Resident 121 revealed an active physician's order for Slow Magnesium/Calcium Oral Tablet Delayed Release 64-106 MG (Magnesium Chloride-Calcium) Give 1 tablet by mouth every morning and at bedtime for hypomagnesemia (low magnesium level). The above findings for Resident 121 were reviewed with the Nursing Home Administrator and Employee 1, Assistant Director of Nursing, on July 31, 2026, at 11:50 AM. Observation of a medication administration pass for Resident 136 with Employee 14 (licensed practical nurse) on July 29, 2026, at 8:32 AM revealed Employee 14 administered one tablet of vitamin D3 (also known as cholecalciferol, a fat-soluble vitamin essential for calcium absorption, bone health, and immune system support), 400 units, to Resident 136. Clinical record review for Resident 136 revealed an active physician order dated January 23, 2026, for staff to administer cholecalciferol oral tablet, 100 micrograms (4000 units), one tablet by mouth in the morning for vitamin D deficiency. Interview with Employee 15 (licensed practical nurse) on July 31, 2026, at 11:09 AM revealed that a new supply of medications from pharmacy for Resident 136 continued to label Resident 136's vitamin D3 supplement as 400 units. Employee 15 confirmed that Resident 136's active physician order instructed staff to administer 4000 units in the morning. The surveyor reviewed the above concern related to Resident 136's cholecalciferol medication error during an interview with the Nursing Home Administrator and Employee 1 on July 31, 2026, at 11:50 AM. 28 Pa. Code 211.9(a)(1) Pharmacy services 28 Pa. Code 211.10(c) Resident care policies 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 review of select facility policies and procedures, clinical record review, and staff interview, it was determined that the facility failed to provide accurate education regarding the pneumococcal immunization and that each resident was offered a pneumococcal immunization, unless the immunization was medically contraindicated, for four of five residents reviewed for immunization concerns (Residents 11, 17, 157, and 177). 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. The facility policy entitled, Pneumococcal Vaccine, last reviewed without changes on June 25, 2026, revealed that residents will be offered pneumococcal vaccines to aid in preventing pneumonia/pneumococcal infections. This will be done at the time of admission and ongoing as needed. Upon admission, residents will be assessed for eligibility to receive the pneumococcal vaccine series, and when indicated, will be offered the vaccine unless medically contraindicated or the resident has already been vaccinated. Administration of the pneumococcal vaccines or revaccinations will be made in accordance with current Centers for Disease Control and Prevention (CDC) recommendations at the time of vaccination. The Pneumococcal Vaccine Timing for Adults grid included in the facility's pneumococcal immunization program and available at https://www.cdc.gov/pneumococcal/downloads/Vaccine-Timing-Adults-JobAid.pdf revealed that shared clinical decision-making for adults [AGE] years old or greater who already completed the series with PCV13 and PPSV23 is that together, with the resident, vaccine providers (the facility) may choose to administer PCV20 or PCV21 to adults [AGE] years old or older when five or more years has elapsed since the resident received the PCV13 (but not PCV15, PCV20, or PCV21) at any age and PPSV23 at or after the age of [AGE] years old. The facility policies provided did not stipulate the frequency that staff would ensure that residents received education regarding available pneumococcal immunizations during their ongoing admission to the facility (e.g., annually), or that they would be offered appropriate pneumococcal immunizations during their ongoing admission to the facility. Clinical record review for Resident 157 revealed that the facility admitted him on August 20, 2024. Review of Resident 157's immunization record revealed that he received the Prevnar13 vaccine (continued on next page)		

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	on July 24, 2015, (when he was [AGE] years old) and the Pneumovax vaccine on November 8, 2019 (when he was [AGE] years old). Based on shared clinical decision-making, Resident 157 was eligible to receive either the PCV20 or PCV21 vaccine at least 5 years after the last pneumococcal vaccine (November 8, 2024). Review of a 2024 Consent/Declination of Pneumococcal Conjugate Vaccine document dated August 20, 2024, revealed that Resident 157 declined a pneumococcal vaccine. There was no evidence that the facility reoffered Resident 157 a pneumococcal vaccine in the two years since his admission to the facility. Clinical record review for Resident 177 revealed that the facility admitted her on January 20, 2026. Review of Resident 177's immunization record revealed that she received the Pneumovax23 vaccine on December 15, 2005, (when she was [AGE] years old) and the Prevnar13 vaccine on April 11, 2016 (when she was [AGE] years old). Based on shared clinical decision-making, Resident 177 was eligible to receive either the PCV20 or PCV21 vaccine at least 5 years after the last pneumococcal vaccine dose (April 11, 2021). Review of a Consent for Pneumococcal Vaccine form for Resident 177 revealed that her son declined a pneumococcal vaccine for Resident 177 on January 20, 2026, because she, already received it on (date unknown). There was no evidence that the facility educated Resident 177's son that current CDC guidelines promote a PCV20 or PCV21 vaccine for his mother. Clinical record review for Resident 11 revealed that the facility admitted her on January 15, 2026. Review of Resident 11's immunization record revealed that she received the Pneumovax23 vaccine on January 23, 2003 (when she was [AGE] years old). Review of a Consent/Declination of Pneumococcal Conjugate Vaccine form signed by Resident 11 on January 15, 2026, indicated that she declined the vaccine because she already received it on (date blank). The general information listed on the form has the resident acknowledge that he/she is aware that if he/she received both the PCV13 and PPSV23 vaccines, no further vaccination is warranted. The form did not incorporate current CDC guidelines that stipulate a PCV20 or PCV21 vaccine should be administered to someone who received both the PCV13 and PPSV23 vaccines when five or more years has elapsed since the resident last received a pneumococcal vaccine. Clinical record review for Resident 17 revealed that the facility admitted him on October 2, 2024. Review of Resident 17 immunization record revealed that he received the Prevnar13 vaccine on August 23, 2019, (when he was [AGE] years old) and the Pneumovax23 vaccine on August 20, 2020 (when he was [AGE] years old). Based on shared clinical decision-making, Resident 17 was eligible to receive either the PCV20 or PCV21 vaccine five years after his last pneumococcal vaccine dose (August 20, 2025). Resident 17's clinical record did not contain evidence that the facility offered Resident 17 a pneumococcal vaccine after August 20, 2025. Interview with Employee 19 (registered nurse/infection control prevention coordinator) on July 29, 2026, at 4:42 PM confirmed the facility's pneumococcal immunization plan and the above findings for Residents 11, 17, 157, and 177. 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 review of select facility policies and procedures, clinical record review, and staff interview, it was determined that the facility failed to maintain required documentation of staff COVID-19 immunization status for three of three staff reviewed for COVID-19 immunizations (Employees 6, 21, and 22); and failed to maintain documentation of resident COVID-19 immunization status for two of five residents reviewed for immunization concerns (Residents 11 and 175). Findings include: Review of the facility policy entitled, Infection Control COVID-19 Vaccine Residents and Staff, last reviewed without changes on June 25, 2026, revealed that it is the policy of the facility to provide education to staff and residents/representatives of the benefits and potential side effects associated with the COVID-19 vaccination and offer the vaccine unless it is contraindicated or the staff/resident has already been immunized. Maintain documentation regarding the education provided, the vaccine administration, as well as documentation of refusal. Follow the current CDC, CMS, and PA DOH guidance and regulations related to COVID vaccines. Prior to admission, the admission staff will attempt to verify if the potential resident has received the COVID-19 vaccine and will obtain the manufacturer and dates given. The vaccination information will be recorded in the resident medical record. If the staff member has received the vaccine, a copy of the vaccine card or record will be maintained in the employee medical file. The facility maintains documentation related to staff COVID-19 vaccination that includes at a minimum the COVID-19 vaccine status of staff and related information as indicated by NHSN. The surveyor requested evidence of facility-maintained documentation related to staff COVID-19 vaccination status that included at a minimum the COVID-19 vaccine status of staff as indicated by the Centers for Disease Control and Prevention's National Healthcare Safety Network (NHSN) during interviews with the Director of Nursing and Employee 12 (assistant nursing home administrator) on July 29, 2026, at 1:45 PM, Employee 19 (registered nurse/infection control prevention coordinator) on July 29, 2026, at 4:42 PM, and with the Nursing Home Administrator and Employee 1 (assistant director of nursing) on July 30, 2026, at 1:45 PM. The initial list provided by the facility noted that the COVID-19 vaccination status of 247 out of 249 staff was unknown. The second list provided by the facility and reviewed with Employee 19 on July 31, 2026, at 1:20 PM revealed that seven staff were completely vaccinated, 114 were partially vaccinated, one was granted an exception, and 156 were not vaccinated without exemption/delay. The National Healthcare Safety Network (NHSN) Manual for the 2026 COVID-19 Vaccination Protocol Weekly COVID-19 Vaccination Module for Healthcare Personnel (HCP) stipulated that data sources for the required data elements include management/personnel data (e.g., payroll or attendance records), medical or occupational health records (e.g., electronic health data) vaccination records, claims, instrument-based data, and immunization tracking. HCP can self-report in writing (paper or electronic) that the vaccination was received elsewhere or provide documentation of receipt of the COVID-19 vaccine elsewhere. Documentation must include the date and location of vaccine receipt and vaccine type. Verbal statements are not acceptable proof of vaccination outside the facility for this reporting module. However, HCP can provide verbal statements for medical contraindications to and declination of the COVID-19 vaccine, as written documentation is not required for NHSN reporting. Interview with Employee 6 (registered nurse assessment coordinator) on July 31, 2026, at 12:40 PM revealed that she received COVID-19 immunizations around 2020, but had not received any immunizations since. Interview with Employee 21 (physical therapist assistant) on July 31, 2026, at 12:43 PM revealed that (continued on next page)		

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	she was initially fully vaccinated, however, she had no COVID-19 immunizations since 2021. Interview with Employee 22 (purchasing director/receptionist manager) on July 31, 2026, at 12:46 PM indicated that she received COVID-19 immunizations when they were first made available plus one booster (approximately 2022), however, she has not received any COVID immunizations since then. Interview with Employee 19 on July 31, 2026, at 1:15 PM confirmed that the facility could provide only information that the selected staff were partially vaccinated or that vaccination status was unknown. The facility had no data to indicate the date or vaccine type of COVID-19 immunizations for staff. Clinical record review for Resident 175 revealed that the facility admitted her on June 22, 2026. Resident 175's clinical record contained no data to indicate when she last received a COVID-19 immunization. Review of a COVID-19 Vaccine Consent Form signed by Resident 175's husband on June 22, 2026, revealed that he declined the administration of the vaccine because, she is up to date, however, the date received field was not completed with a date when Resident 175 received a vaccine. The facility had no evidence that COVID-19 immunization administrations were verified with Resident 175's husband or her physician to ensure that she was, in fact, up to date with her immunizations. Clinical record review for Resident 11 revealed that the facility admitted her on January 15, 2026. Review of a Resident COVID-19 Vaccine Consent Form signed by Resident 11 on January 15, 2026, revealed that she refused the immunization because she had received the current recommended COVID-19 vaccine, however, the date field for the most recent COVID-19 immunization was blank. Review of Resident 11's immunization record revealed the most recent COVID-19 immunization was administered on March 12, 2021. Resident 11's clinical record contained no evidence that the facility attempted to verify that Resident 11 did, in fact, receive COVID-19 immunizations per current CDC guidelines. Interviews with Employee 19 on July 29, 2026, at 4:42 PM and July 31, 2026, at 9:36 AM confirmed the above findings for Residents 11 and 175. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18(b)(1) Management 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, observation, and resident and staff interview, it was determined that the facility failed to implement a comprehensive person-centered care plan regarding a continuous glucose monitoring device and infection for two of 35 residents reviewed (Residents 13 and 16). Findings Include: Clinical record review for Resident 16 revealed an active order for a Dexcom G7 (a dedicated handheld device that wirelessly receives glucose data from a Dexcom continuous glucose monitor (CGM) worn on your body and updates at a pre-set interval). During an interview with Resident 16 on July 28, 2026, at 12:00 PM, a CGM device sitting on her bedside table alerted the resident to her most recent blood sugar reading. The resident stated that the staff look at her CGM device routinely. Further review of Resident 16's clinical record revealed no care plan was developed related to the resident's CGM device or associated resident monitoring/assessment. The above information for Resident 16 was reviewed in a meeting with the Nursing Home Administrator and Director of Nursing on July 29, 2026, at 2:15 PM. The Nursing Home Administrator confirmed these findings on July 30, 2026, at 2:00 PM. Clinical record review for Resident 13 revealed a diagnosis list that included aneurysm (ballooning in a blood vessel) of specified arteries and methicillin susceptible staphylococcus aureus (an infection caused by a type of bacteria commonly found on the skin) infection. A significant change/five-day Minimum Data Assessment (MDS, an assessment completed at specific intervals to determine care needs) for Resident 13 dated July 12, 2026, revealed a diagnosis of aneurysm of specified arteries and methicillin susceptible staphylococcus aureus infection. This MDS also revealed Resident 13 received IV (intravenous - given through a vein) medication on admission and while a resident, as well as antibiotic (medication used to treat bacterial infections) medication. During an interview with Resident 13 on July 29, 2026, at 9:04 AM, they indicated that the main reason for the admission to the facility was due to an infection that required IV antibiotic therapy. Observation on July 29, 2026, at 9:04 AM revealed an IV pole and empty IV antibiotic bag in Resident 13's room. Clinical record review for Resident 13 on July 29, 2026, at 11:30 AM revealed she was readmitted to the facility on [DATE]. Further review revealed that Resident 13 had no care plan (an outline of an individual's health needs, specific care requirements, and the actions necessary to achieve desired health outcomes) implemented related to ongoing infection with antibiotic treatment. The care plan related to Resident 13's infection with antibiotic treatment was requested during a meeting with the Nursing Home Administrator and Employee 1, Assistant Director of Nursing, on July 30, 2026, at 2:05 PM. The facility confirmed during a meeting with the Nursing Home Administrator on July 31, 2026, at 9:25 AM that there was no active care plan for Resident 13's infection with antibiotic treatment until after the surveyor's request on July 30, 2026. 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 - Few	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 that the resident's attending physician addressed and responded appropriately to consultant pharmacy recommendations for one of five residents reviewed (Resident 17). Findings include: The facility policy entitled Consultant Pharmacist Reports, last reviewed without changes on June 25, 2026, revealed the consultant pharmacist performs a comprehensive review of each resident's medication regimen at least monthly. Findings and recommendations are reported to the Director of Nursing, Medical Director, and the attending physician. The consultant pharmacist identifies irregularities through a variety of sources including medication administration records (MARs), prescriber's orders, progress notes of prescribers, nurses, and/or consultants, the Resident Assessment Instrument (RAI), laboratory and diagnostic test results, behavior monitoring information, the facility staff, the attending physician, and from interviewing, assessing, and/or observing the resident. Recommendations are acted upon and documented by the facility staff and/or the prescriber. Prescriber accepts and acts upon suggestion or rejects and provides an explanation for disagreeing in a timely manner. Clinical record review for Resident 17 revealed a consultant pharmacist recommendation dated February 16, 2026, recommending lab monitoring including A1C (a lab test that measures your average blood sugar levels over the past two to three months), FBS (fasting blood sugar), TSH (a lab test measures thyroid stimulating hormone to evaluate how well your thyroid is working), and lipid panel (a blood test that measures cholesterol and triglyceride levels to assess your risk of heart disease and other cardiovascular conditions) to ensure safety and efficacy of the medication therapy. Resident 17's physician signed the pharmacist recommendation on February 17, 2026. Further review of Resident 17's clinical record revealed there was no evidence that the facility completed the recommended lab monitoring. Interview with the Nursing Home Administrator on July 31, 2026, at 11:02 AM confirmed the above findings for Resident 17. 28 Pa. Code 211.9 (k) Pharmacy services 28 Pa. Code 211.12(d)(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, clinical record review, and staff interview, it was determined that the facility failed to ensure medication security on one of five nursing units (third-floor, Residents 157 and 194); and failed to ensure medication labeling according to acceptable standards of practice for one of three residents observed for medication administration (Resident 136). Findings include: Observation of the third-floor nursing unit on July 28, 2026, at 3:26 PM revealed an unattended medication cart in the hallway, unlocked, with one drawer partially opened and extended from the medication cart. Keys were observed on top of the cart and the lid to a laptop computer was opened. The computer screen displayed information that pertained to a facility resident. Continued observation of the unattended medication cart until July 28, 2026, at 3:28 PM revealed that no staff returned to the cart until Employee 13 (registered nurse) exited Resident 157's room. Employee 13 acknowledged that the medication drawer was open from the cart. Employee 13 stated that she pushed it shut but it opened again. Employee 13 acknowledged that the push button lock on the medication cart (that locks all doors that are closed) was also left open. Employee 13 acknowledged that she did not have the medication cart keys with her while she was in the resident's room and was not within sight of the medication cart that was in the hallway. Employee 13 stated that the male resident, Resident 194, who stood on the other side of the medication cart with his walker, had the diagnosis of dementia (disease of the brain that limits the ability to think and remember). The surveyor reviewed the above concern regarding the unsecured medication cart during an interview with the Nursing Home Administrator and Employee 1 (assistant director of nursing) on July 30, 2026, at 1:45 PM. Observation of a medication administration pass for Resident 136 with Employee 14 (licensed practical nurse) on July 29, 2026, at 8:32 AM revealed Employee 14 prepared Resident 136's metoprolol (medication used to lower blood pressure; available as metoprolol tartrate (immediate-release) or metoprolol succinate (extended-release), each with distinct dosing schedules and approved uses) 25 milligrams (mg) medication for administration. The medication packaging did not include if the medication was metoprolol tartrate or metoprolol succinate. Interview with Employee 14 on the date and time of the observation revealed that Resident 136's physician order was for her to receive metoprolol tartrate, however, she needed to find a picture of the medication on the internet and compare it to a description of the tablet on the packing to ensure that the resident would receive metoprolol tartrate as supplied by pharmacy. Employee 14 confirmed that the medication labeling did not include the complete name of the medication. Interview with Employee 15 (licensed practical nurse) on July 31, 2026, at 11:09 AM revealed that a new supply of medications from pharmacy for Resident 136 continued to label Resident 136's metoprolol medication without the full name of the medication (tartrate or succinate). Employee 15 confirmed that she would not know which version of the medication pharmacy supplied by the labeling on the medication packaging. The surveyor reviewed the concern related to Resident 136's metoprolol medication labeling during an interview with the Nursing Home Administrator and Employee 1 on July 31, 2026, at 11:50 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 - Few	Provide and implement an infection prevention and control program. Based on clinical record review, observation, and staff and family interview, it was determined that the facility failed to implement transmission-based precautions to ensure an environment free from the potential spread of infection on one of five nursing units (third-floor, Residents 157 and 175). Findings include: Clinical record review for Resident 157 revealed an active physician's order dated July 25, 2026, to implement Contact Precautions (Contact precautions are infection control measures designed to prevent the spread of infectious agents through direct or indirect contact with patients or contaminated surfaces. Contact precautions are implemented for patients known or suspected to have infections that can be transmitted by direct contact (skin-to-skin) or indirect contact (via contaminated objects or surfaces) C diff (C. diff infection is a bacterial infection of the colon caused by Clostridioides difficile, often triggered by antibiotic use and capable of causing severe diarrhea) Positive. Observation of Resident 157's room on July 28, 2026, at 3:00 PM revealed a sign on his doorway for contact precautions isolation. The sign instructed to not use alcohol-based sanitizers for hand hygiene; to use soap and water. The instructions listed to don gloves upon entry into the room or cubicle, wear gloves whenever touching the patient's intact skin or surfaces and articles in close proximity to the patient and remove gloves before leaving the patient room. [NAME] a gown upon entry into the room or cubicle. Remove the gown and observe hand hygiene before leaving the patient-care environment. Observation of Resident 157 on July 28, 2026, at 3:00 PM revealed Employee 13 (registered nurse) entered Resident 157's room with medications. Employee 13 did not don a gown or gloves before approaching Resident 157 who sat in his recliner chair. Employee 13 leaned next to Resident 157's face to speak into his ear as he was hard of hearing. Employee 13 placed her hands on the armrest of Resident 157's recliner while leaning next to his face. After administering Resident 157's medications, Employee 13 did not wash her hands before leaving his room. Observation of the third-floor nursing unit (where Resident 157 resided) on July 28, 2026, at 3:28 PM revealed Employee 13 exited Resident 157's room wearing a gown and gloves. Employee 13 doffed her gown and gloves in the hallway, next to the medication cart, and disposed of the gown and gloves in the garbage receptacle mounted to the side of the medication cart. Employee 13 did not perform any hand hygiene before touching the medication cart and keys to the medication cart. Interview with Employee 13 on the date and time of this observation indicated that she utilized hand sanitizer when she left Resident 157's room earlier on July 28, 2026, at 3:00 PM. Review of the signage on Resident 157's doorway with Employee 13 confirmed that the instructions stipulated to not use alcohol-based sanitizer but soap and water for hand hygiene. Employee 13 confirmed that she had to get close to Resident 157 during the first observation because he could not hear her and she wanted to ask him if he understood his C-diff diagnosis. She confirmed that she did not wear a gown and gloves when she did so and that she came into substantial contact with his recliner chair to get close enough to him to assist him to understand her. She confirmed that she did not wash her hands when she left his room the first time. Employee 13 confirmed that she should have removed her gown and gloves and washed her hands in Resident 157's bathroom before exiting the room. Clinical record review for Resident 175 revealed a laboratory report dated July 23, 2026, that confirmed Klebsiella pneumoniae ESBL (a multidrug-resistant bacterium producing extended-spectrum beta-lactamases, that make many common antibiotics ineffective) in Resident 175's urine specimen collected July 21, 2026. Observation of Resident 175's room on July 28, 2026, at 12:54 PM revealed a sign on her doorway to implement contact precautions. Resident 175's husband was in her room, sitting in a wheelchair, without any gown or glove use. Employee 17 (nurse aide) was also in Resident 175's room (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	without a gown or gloves. Interview with Resident 175's husband on the date and time of the observation revealed that no staff educated him to wear a gown and gloves when in his wife's room or having physical contact with her or her environment. Resident 175's husband stated that staff had his wife upset at this time because they wore gowns and gloves for the first time and neither he nor his wife understood why they did so since she has had urinary tract infections in the past and has had this one for several days. Interview with Employee 5 (licensed practical nurse) on July 28, 2026, at 12:54 PM confirmed that Resident 175 required contact precautions due to diagnosed ESBL in her urine. Interview with Employee 17 on July 28, 2026, at 12:56 PM revealed that she did not wear a gown and gloves when observed by the surveyor attaching the lift sling for Resident 175 since she was only hooking up the sling for the lift, and that she had placed the sling under the resident earlier. Employee 17 did not identify that she should have worn a gown and gloves when attaching Resident 175's sling to the lift due to the potential for substantial contact with Resident 175 and her environment while completing the task. The surveyor reviewed the above infection control concerns during an interview with the Director of Nursing and Employee 12 (assistant nursing home administrator) on July 29, 2026, at 1:45 PM. 28 Pa. Code 211.12(d)(1)(5) Nursing services		

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

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

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For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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F 0814 Level of Harm - Potential for minimal harm Residents Affected - Many	Dispose of garbage and refuse properly. Based on observation and staff interview, it was determined that the facility failed to properly contain and dispose of garbage at the observed facility trash dumpsters. Findings include: Observation of the facility's main dumpsters located in the rear of the facility on July 28, 2026, at 9:40 AM revealed the following: There were multiple disposable gloves (at least 11 observed) on the ground adjacent to the dumpsters and also located outside of the perimeter fence around the dumpsters. This area also contained small, discarded paper items, a plastic spoon, and a personal hand sanitizer container. The above information was reviewed in a meeting with the Director of Nursing and Employee 12, Assistant Nursing Home Administrator, on July 29, 2026, at 1:45 PM. A follow-up observation of the dumpsters on July 31, 2026, at 12:02 PM revealed there were three disposable gloves on the ground adjacent to the dumpsters. 28 Pa. Code 201.14(a) Responsibility of licensee		