

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

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395831	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/05/2025
NAME OF PROVIDER OR SUPPLIER Schuylkill Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1000 Schuylkill Manor Rd Pottsville, PA 17901	
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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on clinical record review, observation, and staff and resident interview, it was determined that the facility failed to provide a reasonable accommodation of needs for one of seven sampled residents. (Resident 3) Findings include: Clinical record review revealed that Resident 3 had diagnoses that included hemiparesis and unsteadiness on feet. Review of the care plan revealed that the resident required assistance from two staff and a mechanical lift for transfers, assistance from two staff for toileting (staff were to provide assistance with toileting as needed), and that the resident had been educated to call staff for assistance. On August 5, 2025, at 11:09 a.m., the resident's call bell was observed to be lit outside the room. At 11:15 a.m., the call bell remained activated. At that time, Resident 3 stated that she rang the call bell to notify staff that she required assistance to the bathroom; a staff member told her they would return with another staff member to provide assistance, but no one had returned. The resident's call bell continued to remain lit at 11:40 a.m., and at that time, Resident 3 stated that no staff member had returned to offer assistance. Staff did not return to Resident 3's room to provide assistance until 11:48 a.m., 39 minutes after the resident's call bell was initially observed to have been activated. In an interview on August 5, 2025, at 1:52 p.m., the Director of Nursing confirmed that staff were to provide a timelier response to the call bell. 28 Pa. Code 211.12(d)(1)(5) Nursing services.		

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: 395831	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/05/2025
NAME OF PROVIDER OR SUPPLIER Schuylkill Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1000 Schuylkill Manor Rd Pottsville, PA 17901	
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 interview, it was determined that the facility failed to implement physician's orders for two of seven sampled residents. (Residents 1 and 2) Findings include: Clinical record review revealed that Resident 1 had diagnoses that included diabetes mellitus. Review of the care plan revealed that staff were to obtain glucometer (device used to measure blood glucose levels) readings and report abnormalities as ordered. A physician's order dated July 11, 2025, directed staff to inject insulin lispro per sliding scale orders and notify the physician for a blood glucose reading of 400 milligrams per deciliter (mg/dL) or higher. Review of Resident 1's clinical record revealed that on July 11, 2025, staff noted a blood glucose level of 438 mg/dL at 5:01 p.m. There was no evidence that the resident's physician was notified of the blood glucose reading that was above 400 mg/dL, per the physician's order. In an interview on August 5, 2025, at 3:10 p.m., the Director of Nursing (DON) confirmed that there was no evidence that staff notified the resident's physician of the blood glucose level of 438 mg/dL, per the physician's order. Clinical record review revealed that Resident 2 had diagnoses that included hypertension (high blood pressure). Physician's orders dated April 6, 2025, and May 1, 2025, directed staff to check the resident's blood pressure twice per day and administer clonidine (a medication to treat high blood pressure) as needed, every eight hours if Resident 2's systolic blood pressure was greater than 160 millimeters of mercury (mm Hg), or diastolic blood pressure was greater than 100 mm Hg. Review of Resident 2's clinical record revealed that on July 10, 2025, at 6:14 p.m., staff noted the resident's blood pressure to have been 165/89 mm Hg. On July 26, 2025, at 8:04 a.m., staff noted the resident's blood pressure as 187/107 mm Hg. There was no evidence that staff administered the clonidine at those times on July 10 and 26, 2025, when the resident's systolic blood pressure was greater than 160 mm Hg, and diastolic blood pressure was greater than 100 mm Hg, per the physician's order. In interviews on August 5, 2025, at 3:28 p.m. and 3:38 p.m., the DON confirmed that there was no evidence that staff administered the medication when the resident's systolic blood pressure was greater than 160 mm Hg and diastolic blood pressure was greater than 100 mm Hg, per the physician's order. 28 Pa. Code 211.12(d)(1)(5) Nursing services.		