STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395831	A. Building B. Wing	12/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Schuylkill Center	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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on clinical record review, review of facility policy, and staff interview, it was determined that the facility failed to notify the resident's physician of a change in condition for one of 12 sampled residents. (Resident 3)Findings include: Review of the facility policy entitled, Change in a Resident's Condition or Status, last reviewed January 17, 2025, revealed that the facility would promptly notify the resident's attending physician of changes in the resident's medical condition. Clinical record review revealed that Resident 3 had diagnoses that included dysphagia, anxiety, respiratory failure, and required a feeding tube. A physician's order dated November 4, 2025, directed staff to administer oxygen at two liters per minute (L/min) via nasal cannula every shift. On November 23, 2025, at 6:37 p.m., staff noted that the resident was gurgling and had an oxygen saturation of 49 percent (%) while on supplemental oxygen and required the use of a rebreather mask at ten L/min and staff would notify the physician if his condition worsened. At 10:07 p.m., staff noted that the resident was choking on his saliva, required suctioning and a breathing treatment, his temperature was 101.1 degrees Fahrenheit, which indicated a fever, and he was again provided with an oxygen mask to increase his oxygen saturation. On November 24, 2025, at 9:55 a.m., staff noted that the resident required five L/min of oxygen via a nasal cannula, which was greater than the physician's order, to maintain oxygen saturation at 90%. There was no evidence that the resident's physician or any practitioner was notified of the resident's change in condition or assessed the resident until the following day, November 24, 2025, at 9:55 a.m.In an interview on December 11, 2025, at 2:29 p.m., the Director of Nursing (DON) stated that the physician should be notified of a change in condition at the time it is identified. At 3:41 p.m., the DON stated that there was no evidence the resident's physician or a provider was notified of the change in condition until the following day. 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

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(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 physicians' orders for three of 14 sampled residents. (Residents 1, 2, 4)Clinical record review revealed that Resident 1 had diagnoses that included diabetes with hyperglycemia (high level of sugar), chronic kidney disease, and heart failure. Review of the care plan revealed that the resident had diabetes and used insulin. The intervention was for staff to administer medications per the physician's orders. A physician's order dated August 12, 2025, directed staff to administer a short acting insulin injection (Admelog) of four units with meals. Review of the manufacturer instructions for Ademlog revealed that the insulin was to be given 15 minutes before or immediately after a meal. Review of the resident details of the Medication Administration Record (MAR) for December 2025, revealed that Resident 1 was administered Ademlog at 12:15 p.m. on December 11, 2025. Observation on December 11, 2025, at 12:30 p.m. revealed that Resident 1 was seated in the dining room on the nursing unit. Resident 1 was not served her meal tray until 1:15 p.m., an hour after she was administered the mealtime insulin. Clinical record review revealed that Resident 2 had diagnoses that included diabetes with diabetic retinopathy, chronic kidney disease, and dementia. Review of the care plan revealed that the resident had diabetes and used insulin. The intervention was for staff to administer medications per the physician's orders. A physician's order dated June 1, 2025, directed staff to administer three units of a short acting insulin injection (Humalog) with meals. Review of the manufacturer instructions for Humalog revealed that the insulin was to be given 15 minutes before or immediately after a meal. In an interview on December 11, 2025, at 12:40 p.m., licensed practical nurse (LPN) 1 stated that the residents mealtime insulin was administered with the 11:30 a.m. medication pass. Review of the resident details of the MAR for December 2025, revealed that Resident 2 was administered Humalog at 11:15 a.m. on December 11, 2025. Observation on December 11, 2025, at 12:40 p.m. revealed that Resident 2 was seated in the dining room on the nursing unit. Resident 2 was not served her meal tray until 1:24 p.m., over two hours after she was administered the mealtime insulin. In an interview on December 11, 2025, at 2:29 p.m., the Director of Nursing confirmed that the insulin was to be given with meals, per the physicians' orders, and less than one hour before the resident received their meal. Clinical record review revealed that Resident 4 had diagnoses that included hyperglycemia (high blood sugar), dementia, diabetes, and chronic kidney disease. Review of the care plan revealed that the resident had a problem with her endocrine system related to hyperglycemia. The intervention was for staff to measure the resident blood sugar and report abnormalities as ordered. A physician's order dated October 16, 2025, directed staff to obtain fingerstick blood glucose levels and notify the physician if the blood sugar was greater than 400 milligrams per deciliter (mg/dL). Review of the resident's blood sugar logs revealed that on November 29, 2025, staff obtained and recorded a blood sugar reading of 424 mg/dL. On December 5, 2025, staff obtained and recorded a blood sugar reading of 416 mg/dL. There was no evidence that staff notified the resident's physician of the blood glucose readings above 400 mg/dL on November 29, 2025, or December 5, 2025, per the physician's order. In an interview on December 11, 2025, at 3:41 p.m., the Director of Nursing confirmed that there was no evidence that staff notified the physician of the high blood glucose readings, per the physician's order. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	CFR 483.25 Quality of Care Previously cited 8/5/25 28 Pa. Code 211.12(d)(1)(5) Nursing services.

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. Based on review of facility documentation, the facility's meal schedule, resident and staff interview, and observation, it was determined that the facility failed to ensure that meals were served at regularly scheduled times in accordance with resident needs for two of four nursing units. (Homestead and B-wing unit)Findings include: Review of the facility's meal schedule revealed that the scheduled time for steam table delivery for lunch on the Homestead and B-wing dining rooms was 12:00 p.m. Observation on December 11, 2025, at 12:30 p.m., on the B-wing nursing unit revealed residents seated in the dining room and the meal had not yet been served. In an interview at that time, Residents 1, 8, 9, 10, and 11 stated that meals were often served late. Continued observation revealed that the steam table delivery for lunch arrived at the unit with the meal at 12:52 p.m., and service began at 12:58 p.m. Observation on December 11, 2025, at 12:40 p.m., on the Homestead unit revealed residents seated in the dining room, the meal had not yet been served. In an interview at that time, licensed practical nurse (LPN) 1 stated that the lunch meal was scheduled for 12:00 p.m. but typically arrived between 12:00 p.m. and 1:00 p. m. Continued observation revealed that the hot holding table arrived at the unit with the meal at 12:57 p.m., and service began at 1:05 p.m., over one hour after the schedule mealtime. 483.60(f) Frequency of Mealspreviously cited 6/11/25 28 Pa. Code 201.14(a) Responsibility of licensee.

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(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 observations and staff interview, it was determined that the facility failed to maintain sanitary conditions in the kitchen. Findings include: Observation of the kitchen on December 11, 2025, at 10:24 a.m. revealed the following: There was a black substance on the ceiling tiles above the dish machine and doorway that led from the dish room to the main kitchen. The shelves that stored clean dishes were rusted. There was an accumulation of liquid from condensation on the bars that secure the ceiling tiles in place above the food preparation area. When opened, the steamer/hot holding box in the food preparation area released a large amount of steam that billowed out into the kitchen. The flow of air and moisture was not managed to prevent an accumulation of condensation. In an interview during the observation period, the dietary director stated that ventilation system has not adequately managed condensation in the kitchen for over one month and the facility was aware. There were no remedial or temporary measures taken to reduce accumulation of moisture and condensation in the kitchen until repairs were scheduled and completed. The ceiling tiles above the steam table used for tray line were chipped and discolored. In the beverage station area, there was an accumulation of moisture on the bars that secure the ceiling tiles, there were holes in the ceiling tiles. There were open carafes of beverages for resident meals under those areas. The pipe under the sink leaked when the water was running. The box of coffee filters that was on the shelf under the sink was wet and there was an accumulation of liquid on the floor under the shelf. There was an accumulation of a black substance along the base of the wall molding, and the molding was peeling. The wall had stains from dripping liquid/moisture. There was a black substance on the floor surrounding the ice machine. There was an accumulation of dried substances on the outside of a garbage can that was stored next to clean dish racks, some areas were noted to be peeling. Inside of the hot top that was used for meal service, there were gloves, napkins, balled up foil and ladles. In dry storage, there was an accumulation of debris that included food items and packaging under a storge shelf. There was an open can of ginger ale and an open bag of Cheetos on the storage shelves. In the freezer, there was an accumulation of ice on the walls, ceiling, shelves, floor, and food items which included kielbasa and stuffed shells. In the food preparation area, there was an accumulation of debris and dried substances, an open bottle of vegetable oil, and an open box of parchment paper that had an accumulation of debris inside the box and on the paper, on the lower shelves of the food preparation surfaces. There was an accumulation of a black substance that surrounded a fan that was installed in the wall. On the slicer cart, the slicer was assembled, uncovered, and dirty. There were dried particles of debris on the top and middle shelves of the cart. There was a waffle and an empty container of food product behind the slicer cart and under a dish storage surface. There was an accumulation of liquid on the floor in front of the steamer/ hot holding equipment. There was a piece of a drainpipe on the floor under the sink in the food preparation counter, the floor was also dirty.CFR 483.60(i) Food Safety Requirement. Previously cited 6/11/25 28 Pa. Code 201.14(a) Responsibility of licensee.