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	06/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Schuylkill Center	1000 Schuylkill Manor Rd Pottsville, PA 17901

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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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, facility policy review, staff interview, and resident interview, it was determined that the facility failed to ensure that hot beverages were monitored and served at a safe temperature on the nursing units, which placed residents at risk for burn injuries. (Homestead and B Unit) In addition, the facility failed to provide adequate supervision and interventions to prevent accidents related to hot beverages for one of 35 sampled residents which resulted in actual harm of a burn to the abdominal area. (Resident 105) These failures resulted in an Immediate Jeopardy situation. Findings include: Review of documentation by the American Burn Association's Burn Prevention Committee entitled, Scald Injury Prevention, revealed that a scald injury occurred when a hot liquid damaged one or more layers of skin and hot beverages were a frequent source of scald burns. Older adults were the most frequent victims of scald injuries due to thin skin, reduced mobility, and reduced ability to feel heat. Hot liquid at a temperature of 155 degrees Fahrenheit (F) could result in a scald injury in one second. Review of the facility policy entitled, Safety of Hot Liquids, last reviewed January 17, 2025, revealed that staff were to ensure that serving temperatures for hot liquids were maintained not more than 180 degrees F. The policy indicated that hot beverages could be served at temperatures greater than 155 degrees F, contrary to the safety parameters outlined by the American Burn Association's Burn Prevention Committee. Clinical record review revealed that Resident 105 had diagnoses that included Parkinson's disease (progressive movement disorder of the nervous system), Lewy body dementia (a type of dementia that damaged part of the brain that affects cognition, behaviors, and movement), Apraxia (a motor disorder caused by damage to the brain which causes difficulty to perform tasks or movements), xerosis cutis (dry skin), and anxiety. The Minimum Data Set assessment (a periodic evaluation of resident care needs) dated April 10, 2025, indicated that the resident was cognitively impaired and required assistance from staff to set up his meals. The care plan identified that Resident 105 was on a restorative nursing program (a program intended to restore or maintain a specific function) for feeding and that staff was to provide supervision for self-feeding during meals. (continued on next page)

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

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On June 6, 2025, at 5:00 p.m., a nurse noted that while passing medication outside the (Homestead) unit dining room, Resident 105 was heard screaming. The Resident had a coffee cup turned upside down in his hand. A spill was noted to the abdomen and on his lap. Resident 105's clothing was removed and a burn was noted to the center of his abdomen that measured 15 centimeters (cm) by two cm. A verbal order by the physician instructed staff to cleanse the resident's abdominal burn with normal saline solution and apply sliver sulfadiazine ointment (a topical medication primarily used to prevent and treat infections in burn wounds) three times a day for five days and to monitor the burn every shift for changes. In addition, the Resident was to utilize a coffee cup with a lid to prevent future injury. A review of the food temperature form dated June 6, 2025, revealed that the temperature of the hot beverages for dinner were recorded in the kitchen as 174 degrees to 181 degrees F. There was no evidence that the hot beverages were retested prior to serving. On June 8, 2025, at 12:50 p.m., Resident 105 was observed unsupervised in the Homestead dining room drinking coffee. There was no lid on the cup. There was no evidence that the coffee was tested at the point of service. On June 9, 2025, at 11:40 a.m., Resident 105 was observed unsupervised in the Homestead dining room drinking coffee. There was no lid on the cup. There was no evidence that the coffee was tested at the point of service. Observation during a hot beverage audit conducted on the Homestead Unit on June 9, 2025, at 11:55 a.m., at the time the last resident beverage was served, it was determined that the coffee provided to residents and poured from an insulated carafe was 166 degrees F. In an interview during the audit, the Food Service Director confirmed the temperature of the coffee was 166 degrees F. In an interview on June 9, at 11:40 a.m., Activities Employee 1 (AE 1) stated that he did not test the temperature of the coffee before the start of service. He also stated that he did not typically test the temperature of the coffee before serving to residents. There was a lack of evidence to support that any staff were testing the temperature of the coffee before serving to residents. In an interview on June 9, 2025, at 11:45 a.m., Licensed Practical Nurse (LPN 1) stated that she did not typically test the temperature of the coffee before serving it to residents. In interviews on June 9, 2025, at 12:30 p.m., in the dining room on unit B, Residents 65 and 97 stated that the coffee was served too hot to drink and had to sit before drinking it. In an interview on June 9, 2025, at 1:45 p.m., the Director of Nursing stated that Resident 105 should have had a lid on the coffee cup when observed on June 8 and 9, 2025. On June 10, 2025, at 1:32 p.m., a physician noted that Resident 105 was assessed and that the burned area of the abdomen remained pink in color. On June 9, 2025, at 5:45 p.m., the Administrator was notified that the failure to ensure that hot beverages were served at a safe temperature constituted an Immediate Jeopardy situation at F689 K, and the Immediate Jeopardy template was provided. The facility was informed that a corrective action plan was required. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The facility provided an acceptable action plan for removal of Immediate Jeopardy on June 9, 2025, at 9:45 p. m. The facility's action plan contained the following: 1. The temperature of hot beverages would be recorded by a dietary aide on a log at the start of every meal service at the tray line and before the hot beverages leave the kitchen. The temperature would not exceed 150 degrees F before leaving the kitchen. The dietary manager or designee would verify the temperature was taken correctly and sign the procedures on the Tray-Line Food Temperature Log. 2. The facility revised their policy to reflect a safe serving temperature of hot beverages to be between 130 degrees F and 150 degrees F. 3. All scheduled dietary staff who were onsite were educated on the safe service temperature of hot beverages and the procedure to monitor temperatures of hot beverages. The Director of Dining and Nutrition Services will be onsite prior to breakfast June 10, 2025, to educate the dietary staff on the revised Safety of Hot Liquids policy. All nursing and ancillary staff would be educated by June 10, 2025, at 11:59 p.m. Any staff member who was not educated by June 10, 2025, at 11:59 p.m., would not be able to work until the education was completed. Staff would be educated to notify supervisors of unacceptable hot beverage temperatures, and supervisors would be educated to report the high temperature of hot beverages to the dietary department. 4. The Dietary Manager or designee will update the meal tray ticket to ensure adaptive feeding equipment is added to the resident's tray. Nursing staff will ensure that the adaptive equipment is available for the resident's use. An adaptive feeding equipment audit will completed by the Director of Nursing or designee for five residents daily for two weeks and 20 residents weekly for four weeks. 5. The Administrator or designee will conduct audits of the temperature logs daily for two weeks and weekly for four weeks to ensure that temperatures were properly obtained and were within the safe range for service. The results of the audits will be reviewed at the monthly Quality Assurance Performance Improvement meeting. The Quality Assurance Performance Committee will determine the need for further audits. The survey team validated that Immediate Jeopardy was removed on June 9, 2025, at 9:45 p.m., through observation, staff interview, review of staff training, and review of the facility policy and procedure following the facility's implementation of the action plan for removal of the Immediate Jeopardy. 28 Pa. Code 201.14(a) Responsibility of licensee. 28 Pa. Code 201.18(b)(1)(3) Management. 28 Pa. Code 211.10(d) Resident care policies. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. Based on observation and interview, it was determined that the facility failed to post accurate and current nurse staffing information. Findings include: Observations during tours of the facility conducted on June 8, 2025, at 9:35 a.m., and June 9, 2025, at 8:50 a. m., revealed that staffing information posted in the lobby was dated for June 6, 2025. In an interview on June 11, 2025, at 10:30 a.m., the Nursing Home Administrator confirmed that incorrect staffing information was posted. 28 Pa. Code 201.18(b)(3) Management.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observation, clinical record review, review of manufacturer's instructions, and staff interview, it was determined that the facility failed to maintain a medication error rate of less than five percent (%) for two of four nursing units observed on medication administration. (Short Stay, B unit) Findings include: Observations of medication administration on June 8, 2025, from 12:50 p.m. to 1:30 p.m., and June 9, 2025, from 8:45 a.m. to 9:45 a.m., revealed 26 medication opportunities with four medication errors that resulted in a medication administration error rate of 15.38%. Clinical record review revealed that Resident 81 had diagnoses that included chronic obstructive pulmonary disease and diabetes. A review of the physician's order dated May 15, 2025, revealed that staff was to administer one puff of a tiotropium bromide (Spiriva) inhaler orally every day and was to rinse mouth after use. A review of the physician's orders dated January 21, 2025, revealed that staff was to administer 15 units of insulin glargine (LANTUS) pen-injector subcutaneously every morning and at bedtime and four units of insulin aspart (NovoLog) pen-injector subcutaneously three times a day. A review of the manufacturer's prescribing information revealed that users were to wipe the insulin pen tops with an alcohol swabs prior to attaching a needle to them. Observation of the medication pass on June 9, 2025, at 9:05 a.m., revealed that Licensed Practical Nurse (LPN) 3 did not direct Resident 28 to rinse his mouth after using the inhaler and did not clean the tops of the two insulin pens with alcohol prior to attaching the needles. Clinical record review revealed that Resident 158 had diagnoses that included chronic pain and dementia. A review of the physician's order dated May 12, 2025, revealed that staff were to administer an extended relief pain medication (acetaminophen) three times a day. A review of the Acetaminophen Extended-Release Tablets Drug Facts information sheet revealed that extended release acetaminophen tablets should not be crushed. Observation of the medication pass on June 8, 2025, at 1:15 p.m., revealed that LPN 2 crushed the acetaminophen extended release tablet prior to administration. In an interview on June 11, 2025, at 9:36 a.m., the Director of Nursing confirmed that the four medication administration errors occurred. 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 - Few	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 three of four nursing units (Homestead, Short Stay, B unit) Findings include: Review of the Food Council Minutes dated May 20, 2025, revealed that Resident 62 had stated that she had to wait a long time for a meal. In a group interview on June 10, 2025, at 10:00 a.m., Resident 130, stated that the meals were frequently delivered late to the unit, it was an on-going problem, and affected her going to scheduled activities. In interviews conducted on June 8 and 9, 2025, between 12:05 p.m. and 1:45 p.m., Residents 28, 36, and 62, stated that delivery of the meal trucks and steam tables was often late. Review of the facility's meal schedule revealed that the scheduled time for steam table delivery for lunch on the Homestead unit was 12:00 p.m., for B-wing Dining Room was 12:00 p.m., and for the Short Stay unit, it was 12:30 p.m. The scheduled time for the second meal truck delivery for B North unit, was 12:57 p.m. There was a grace period of 15 minutes for meal delivery. Observation on June 8, 2025, revealed the Homestead steam table arrived at 12:50 p.m., 35 minutes late. The Short Stay unit steam table arrived at 1:34 p.m., 49 minutes late, and the second meal truck for B North unit arrived at 1:45 p.m., 33 minutes late. In an interview conducted on June 8, 2025, at 1:45 p.m., Resident 86 was observed not to have his meal tray and stated meals were typically late. In an interview on June 11, 2025, at 9:35 a.m., the Director of Nursing confirmed the meal service should have been delivered according to the scheduled delivery times. 28 Pa. Code 201.14(a) Responsibility of licensee.

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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 facility policy review, observation, and staff interview, it was determined that the facility failed to store and serve food in a sanitary manner in the dietary department and on one of four nursing units. (Homestead) Findings include: Review of the facility policy entitled, Food Preparation and Service, dated January 17, 2025, revealed that staff were to change gloves between tasks and to wear hair restraints to cover all facial hair so that hair did not contact food. Review of the facility policy entitled, Use-By Dating Guidelines, dated January 17, 2025, revealed that staff were to label opened food items with a use-by date and cheese and lunch meat were to be used within seven days of opening. Observations during the kitchen tour on June 8, 2025, at 9:50 a.m., revealed the following: In cooler one, a large container of tea was not dated. In cooler three, there was an opened bag of sliced turkey lunch meat with an opened date of May 22, 2025. Juices from this bag were dripping onto a box of pork below it and formed a puddle on the cooler floor. There was an opened bag of sliced ham stored directly next to the leaking turkey lunchmeat bag with a use by date of May 29, 2025. In cooler four, there were two bags of opened shredded cheese that were not dated, a bag of lettuce was opened to air and was stored next to an opened bag of cheddar cheese, two crates of milk were stored directly on the floor, and a juice lid was on the floor, in front of the milk cartons. In the trayline refrigerator, there was a white, dried substance on the outside of the bottom door and on the inside on a shelf. There were three utensil drawers that had dried red food debris on the outside of each. There was a flying insect in the area where uncovered slices of pie were being dished and there were two flying insects in the dish room area. In dry storage, there was a fly on the window and a window that was slightly opened. On the windowsill, there was an area of dried liquid and bug and dust debris across the windowsill. Observation of meal service on the Homestead unit on June 10, 2025, from 12:06 p.m. to 12:20 p.m., revealed Dietary Employee (DE) 1 had facial hair that was not covered while serving food. DE 1 was wearing gloves, but he proceeded to touch the phone and then handled resident plates and utensils without changing gloves or performing hand hygiene. DE 1 was observed using the same gloved hands to retrieve Salisbury steak from the pan to place on resident meal trays. During the observation period, DE 1 continued to change tasks and did not change gloves or perform hand hygiene after any of the task changes. In an interview on June 10, 2025, the Administrator confirmed that dietary staff were to use utensils to serve the meat instead of their gloved hands. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	CFR 483.60(i) Food Safety Requirement. Previously cited 5/10/24 28 Pa. Code 201.14(a) Responsibility of licensee.

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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, it was determined that the facility failed to dispose of trash and refuse properly. Findings include: Observation of the dumpster area on June 8, 2025, at 10:30 a.m., revealed various items on the ground next to the garbage dumpsters which included multiple used gloves, plastic debris, and condiment packets. There was a waffle and a pile of animal droppings on the ground behind the dumpster. One of the dumpsters had four soiled briefs and cloths sticking out from under it. 28 Pa Code 201.18(b)(3) Management.