| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 395831 | A. Building<br>B. Wing | 05/20/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Schuylkill Center | 1000 Schuylkill Manor Rd<br>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 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>Based on observation and staff interview, it was determined that the facility failed to ensure food was stored under sanitary conditions in the dietary department.Findings include: Observations during the kitchen tour on May 17, 2026, at 10:00 a.m., revealed the following: In the walk-in refrigerator, there was a tray of ten side salads and two chef's salads with brown lettuce prepared for service at lunch. On the second shelf of the walk-in refrigerator, there was a tray with food prepared for the residents' lunch meal with four individual four-ounce yogurt cups with an expiration date of May 9, 2026. There were two cases of four-ounce yogurt cups with expirations dates of May 9 and May 15, 2026. In the walk-in freezer, there was one cup of vanilla ice cream. The lid was not sealed and the product was open to the air. On May 17, 2026, at 10:25 a.m., the Certified Dietary Manager confirmed that the items observed were improperly stored. CFR 483.60(i) Food Safety Requirement.Previously cited 6/11/25 28 Pa. Code 201.14(a) Responsibility of licensee. 28 Pa. Code 201.18(b)(3) Management. |

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

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

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|---|---|
| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, it was determined that the facility failed to provide a safe, clean, and comfortable environment on two of four nursing units. (Homestead and C Units)Findings include:Observations on May 17, 2026, from 09:41 a.m. through 1:10 p.m., and May 20, 2026 from 8:40 a.m. through 12:00 p.m., revealed the following: In room [ROOM NUMBER], there was peeling wallpaper behind the bed and the cover of the window ledge was peeling. The window was open and could not be closed.In room [ROOM NUMBER], the right window was opened and could not be closed. Clear tape was stuck to the glass.In room [ROOM NUMBER], the right closet door was missing the metal handle. There was thick, dark brown staining around the base of the toilet. The bathroom floor tiles were dirty around the baseboards and an area behind the toilet had worn and rippled tiles.In room [ROOM NUMBER], a repair on the wall at the bottom right of the window was unpainted with three spots of spackling.In room [ROOM NUMBER], the bathroom floor baseboards around the toilet were dirty with dust and grime. There was a tear in the painted wall adjacent to the toilet.On the Homestead unit, there was a ceiling tile with brown stains in the main dining room. The microwaves in the dining room and lounge had food debris on the inside. The wallpaper to the right of the central bathroom door was peeling. In the Homestead central bathroom, a dried, brown substance was observed on the back railing of the shower chair. The floor tiles were chipped. There was a brown substance in the tile grout of the shower room floor, a black substance on the baseboard tile to the right of the shower entry, a shower rod with rust spots, a plastic light cover with cracks, peeling wall paper by the tub, a crack in the ceiling tile above the light near the shower gurney, and the shower gurney mattress was peeling and had several cracks. The handle of the bathroom in room [ROOM NUMBER] was broken.28 Pa. Code 201.18(e)(2.1) Management. |

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| F 0628<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies.<br><br>Based on clinical record review and staff interview, it was determined that the facility failed to provide copies of the written transfer notices to a representative of the Office of the State Long-Term Care Ombudsman for 12 out of 12 residents who were transferred out of the facility. (Residents 1, 3, 7, 15, 19, 47, 90, 109, 137, 141, 158, and 178)Findings include: Clinical record review revealed that Resident 1 was transferred to the hospital on January 16, 2026, after a change in condition. There was no documented evidence to support that the facility sent a copy of the transfer notice to a representative of the Office of the State Long-Term Care Ombudsman. Clinical record revealed that Resident 3 was transferred to the hospital on January 27, 2026, and February 12, 2026, after changes in condition. There was no documented evidence to support that the facility sent a copy of the transfer notice to a representative of the Office of the State Long-Term Care Ombudsman. Clinical record review revealed that Resident 7 was transferred to the hospital on March 24, 2026, after a change in condition. There was no documented evidence to support that the facility sent a copy of the transfer notice to a representative of the Office of the State Long-Term Care Ombudsman. Clinical record review revealed that Resident 15 was transferred to the hospital on February 6, 2026, after a change in condition. There was no documented evidence to support that the facility sent a copy of the transfer notice to a representative of the Office of the State Long-Term Care Ombudsman. Clinical record review revealed that Resident 19 was transferred to the hospital on February 2, 2026, after a change in condition. There was no documented evidence to support that the facility sent a copy of the transfer notice to a representative of the Office of the State Long-Term Care Ombudsman. Clinical record review revealed that Resident 47 was transferred to the hospital on February 10 and February 24, 2026, after a change in condition. There was no documented evidence to support that the facility sent a copy of the transfer notice to a representative of the Office of the State Long-Term Care Ombudsman. Clinical record review revealed that Resident 90 was transferred to the hospital on April 28, 2026, after a change in condition. There was no documented evidence to support that the facility sent a copy of the transfer notice to a representative of the Office of the State Long-Term Care Ombudsman. Clinical record review revealed that Resident 109 was transferred to the hospital on March 2, 2026, after a change in condition. There was no documented evidence to support that the facility sent a copy of the transfer notice to a representative of the Office of the State Long-Term Care Ombudsman. Clinical record review revealed that Resident 137 was transferred to the hospital on January 29, 2026, after a change in condition. There was no documented evidence to support that the facility sent a copy of the transfer notice to a representative of the Office of the State Long-Term Care Ombudsman. Clinical record review revealed that Resident 141 was transferred to the hospital on January 18, 2026, after a change in condition. There was no documented evidence to support that the facility sent a copy of the transfer notice to a representative of the Office of the State Long-Term Care Ombudsman. Clinical record review revealed that Resident 158 was transferred to the hospital on February 26, 2026, after a change in condition. There was no documented evidence to support that the facility sent a copy of the transfer notice to a representative of the Office of the State Long-Term Care Ombudsman. Clinical record review revealed that Resident 178 was transferred to the hospital on March 1, 2026, after a change in condition. There was no documented evidence to support that the facility sent a copy of the transfer notice to a representative of the Office of the State Long-Term Care Ombudsman. In an interview on May 20, 2026, at 11:45 a.m., the Director of Social Services confirmed that the written copies of the transfer notices were not sent to the Office of the State Long-Term Care Ombudsman. 28 Pa. Code 201.14(a) Responsibility of licensee.<br><br>28 Pa. Code 201.18(b)(3) Management. |

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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, observation, and staff interview, it was determined that the facility failed to provide feeding assistance in a manner that maintained dignity for one of 33 sampled residents. (Resident 8)Findings include:Clinical record review revealed that Resident 8 had diagnoses that included Parkinson's disease, heart disease, and a history of strokes. Review of the Minimum Data Set (MDS) assessment dated [DATE], revealed the resident had severe cognitive impairment and was dependent on staff for assistance with eating. According to the care plan, the resident was at risk for a nutritional deficit with an intervention for staff to provide assistance with eating. On May 17, 2026 at 12:20 p.m., Nurse aide (NA) 2 was observed hand-feeding lunch to the resident while standing over her in the dining room.In an interview on May 19, 2026, at 12:20 p.m., the Administrator confirmed that staff were to sit with residents when feeding them.CFR 483.10(a) Resident Rights.Previously cited 8/5/25. 28 Pa. Code 201.18(e)(1) Management.28 Pa. Code 201.29(a) Resident rights.28 Pa. Code 211.12(d)(1)(5) Nursing services. |

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| F 0558<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Reasonably accommodate the needs and preferences of each resident.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, observation, and staff interview, it was determined that the facility failed to ensure that call bells were accessible for three of 33 sampled residents. (Residents 12, 14, 105) Findings include:Clinical record review revealed that Resident 12 had diagnoses that included hemiplegia and hemiparesis (muscle weakness and paralysis) due to a history of strokes, kidney disease and chronic pain. Review of the Minimum Data Set assessment, dated February 21, 2026, revealed Resident 12 had a severe cognitive impairment but was able to communicate needs to staff, had limited range of motion in both legs and arms, and required substantial assistance from staff for activities of daily living. Review of the care plan dated March 5, 2026, revealed Resident 12 was at risk for falls related to reduced mobility and required staff assistance with transfers and activities of daily living. The interventions included that staff were to provide assistance with toileting, hygiene, and mobility as needed, and were to encourage the resident to use the call bell for assistance. Observation on May 17, 2026, at 11:31 a.m., revealed that Resident 12's call bell cord was tangled beneath the resident's bed, out of reach. The call bell cord was observed on the floor in the same position on May 17, 2026, at 12:58 p.m.Clinical record review revealed that Resident 14 had diagnoses that included Parkinson's disease, dementia and muscle weakness. Review of the MDS dated [DATE], revealed Resident 14 had a moderate cognitive impairment, was able to communicate needs to staff, and required assistance from staff with activities of daily living. Review of the care plan dated April 23, 2026, revealed Resident 14 was at risk for falls related to impaired balance. The interventions included that staff were to provide assistance with toileting, hygiene, and mobility as needed, and were to encourage the resident to use the call bell for assistance. Observation on May 17, 2026, at 11:35 a.m., revealed that Resident 14's call bell cord was beneath the resident's bed, out of reach. The call bell cord was observed on the floor in the same position on May 17, 2026, at 12:53 p.m. Clinical record review revealed that Resident 105 had diagnoses that included Alzheimer's disease, kidney disease, a fractured femur, and chronic back pain. Review of the MDS dated [DATE], revealed Resident 105 had a severe cognitive impairment but was able to communicate needs to staff, had limited range of motion in both legs, and required substantial assistance from staff for activities of daily living. Review of the care plan dated April 5, 2026, revealed Resident 105 was at risk for falls related to reduced mobility and dementia, and required staff assistance with transfers and activities of daily living. The interventions included that staff were to provide assistance with toileting, hygiene, and mobility as needed, and were to encourage the resident to use the call bell for assistance. Observation on May 17, 2026, at 11:29 a.m., revealed that Resident 12's call bell cord was tangled beneath the resident's bed, out of reach. The call bell cord was observed on the floor in the same position on May 17, 2026, at 1:01 p.m. In an interview on May 19, 2026, at 11:40 a.m., the Director of Nursing confirmed that the call bells should have been accessible to the residents.28 PA Code 211.12(d)(1)(5) Nursing services. |

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| F 0676<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason.<br><br>Based on clinical record review, observation, and staff interview, it was determined that the facility failed to provide services to maintain or improve activities of daily living for one of 33 sampled residents. (Resident 153) Findings include: Clinical record review revealed that Resident 153 had diagnoses that included Alzheimer's disease, dementia, and unspecified severe protein-calorie malnutrition. Review of the care plan revealed that the resident had a self-care deficit and required a restorative nursing program (RNP) for eating. The intervention was for staff to assist with cues to encourage the resident to use utensils. On May 18, 2026, at 12:43 p.m., Resident 153 was observed with other residents in the dining room for lunch, using her fingers to scoop ice cream instead of using her spoon. Staff did not redirect the resident or cue her to use utensils. On May 19, 2026, at 12:50 p.m., Resident 153 was again observed in the dining room with other residents eating her lunch meal with her fingers. Nurse aide (NA) 3 was observed at the same table as Resident 153. Staff did not redirect the resident or cue her to use utensils. In an interview on May 20, 2026, at 2:28 p.m., the Director of Nursing confirmed that staff were to assist Resident 153 with eating. 28 Pa. Code 211.12(d)(1)(5) Nursing services. |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, observation, and staff interview, it was determined that the facility failed to prevent accident hazards for one of 33 sampled residents. (Resident 146)Findings include: Clinical record review revealed that Resident 146 had diagnoses that included unspecified dementia, anxiety, and need for assistance with personal care. A review of the Minimum Data Set (MDS) assessment dated [DATE], revealed that Resident 146 was severely impaired for daily decision-making and required assistance for maintaining personal hygiene. His care plan indicated that he required extensive assistance from staff to complete activities of daily living. On May 17, 2026, at 11:55 a.m., Resident 146 was observed in the doorway of his room with a greasy substance on his face and clothes. Nurse aide (NA) 1 cleaned Resident 146's face, identified the substance as Remedy Essentials moisturizing ointment from a tube belonging to the resident's roommate, moved the tube of lotion to the closet, out of reach, and left. The resident was then observed withdrawing another tube of Remedy Essentials moisturizing ointment from his bedside table drawer. On May 18, 2026, at 8:35 a.m., the moisturizing ointment and additionally, antifungal cream, were observed in the resident's bedside table drawer, where they remained accessible to a cognitively impaired resident. In an interview on May 19, 2026, at 11:39 a.m., Registered Nurse (RN) 1 confirmed that the antifungal cream and ointment should not have been accessible to the resident.CFR 483.25(d) Accidents. Previously cited 6/11/25 and 9/5/25. 28 Pa. Code 211.12(d)(1)(5) Nursing services. |

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| F 0699<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide care or services that was trauma informed and/or culturally competent.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and staff interview, it was determined that the facility failed to assess residents with a diagnosis of post-traumatic stress disorder (PTSD) and develop and implement an individualized person-centered care plan to render trauma informed care for one of 33 sampled residents. (Resident 14)Findings include:Clinical record review revealed that Resident 14 was admitted to the facility on [DATE] , 2026, with diagnoses that included quadriplegia and PTSD related to military service and an auto accident. Review of the Minimum Data Set assessment dated [DATE], revealed that the resident had no cognitive impairment, required substantial assistance from staff for activities of daily living, and had a diagnosis of PTSD. Review of the care plan dated December 9, 2025, revealed no evidence that the facility had developed or implemented specific interventions to address the resident's history of trauma or identify and minimize triggers to prevent re-traumatization. In an interview on May 19, 2026, at 11:40 a.m., the Director of Nursing confirmed that Resident 14 did not have an individualized person-centered care plan to render trauma informed care.28 Pa. Code 211.12(d)(3)(5) Nursing services. |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide and implement an infection prevention and control program.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, clinical record review, observation, and staff interview, it was determined that the facility failed to follow policies and procedures to prevent the spread of infection for two of 33 sampled residents. (Residents 107 and 146)<br><br>Findings include:<br><br>Review of the facility policy entitled, Enhanced Barrier Precautions, last reviewed December 29, 2025, revealed that a gown and gloves were to be used with any high contact resident care activity which included wound care.<br><br>Review of the facility policy entitled Dressings, Dry/Clean, last reviewed December 29, 2025, revealed that hand washing was to be performed after opening products, such as the prescribed dressing, and was to be performed between glove changes.<br><br>Clinical record review revealed that Resident 107 had diagnoses that include peripheral vascular disease (a circulation disorder characterized caused by plaque buildup in blood vessels outside the heart and brain), amputation of the left leg (the surgical removal of the leg) above the knee, and end stage kidney disease. A wound assessment report dated May 15, 2026, revealed that Resident 107 had an arterial ulcer (a wound caused by poor circulation and a lack of oxygen-rich blood reaching extremities). A physician's order dated May 13, 2026, directed staff to cleanse the right heel wound with normal saline solution (a solution of water and salt), paint it with betadine (a topical antiseptic used to kill germs), cover it with gauze, and wrap it with Kling (stretchy gauze wrap used to secure dressings applied to the skin). Review of Resident 107's care plan revealed that the resident had a necrotic area (an area of dead tissue) on the right heel and that staff were to wear a gown and gloves during high contact resident care activities. During an observation of wound care to Resident 107's right heel arterial ulcer, on May 18, 2026, at 10:42 a.m., the licensed practical nurse (LPN 1) did not perform hand hygiene after cleansing the wound with normal saline solution and before opening a package containing a gauze pad. LPN 1 did not perform hand hygiene after pouring betadine from a bottle onto the gauze pad and before applying that same gauze pad to the resident's right heel wound. Additionally, LPN 1 did not wear a gown during the dressing change.<br><br>On May 19, 2026, at 12:00 p.m., the Director of Nursing confirmed that staff did not use appropriate personal protective equipment (PPE) and should have performed hand hygiene during Resident 107's dressing change.<br><br>Clinical record review revealed that Resident 146 had diagnoses that included unspecified dementia, anxiety, and need for assistance with personal care. According to the Minimum Data Set assessment dated [DATE], Resident 146 was severely impaired for daily decision-making and required assistance for toileting. His care plan indicated he needed extensive assistance with one staff member to complete activities of daily living.<br><br>On May 19, 2026, at 9:42 a.m., Resident 146 was observed with feces on his left leg below his buttock walking out of his room without pants, holding his underwear. He placed the soiled underwear on the second shelf of the clean linen cart and returned to his room. At 10:30 a.m., staff were observed using linens from the second shelf of the clean linen cart to change the linens in Resident 146's room. The soiled underwear was observed to still be on the clean linen cart at that time and remained there until<br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 10:49 a.m., at which time the registered nurse (RN 2) acknowledged that the soiled underwear was still on the clean linen cart.<br><br>In an interview on May 19, 2026, at 11:25 a.m., the Director of Nursing acknowledged that the infection control policy had not been followed.<br><br>28 Pa. Code 211.10(d) Resident care policies.<br><br>28 Pa. Code 211.12(d)(1)(5) Nursing services. |

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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 0883<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop and implement policies and procedures for flu and pneumonia vaccinations.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, clinical record review, and staff interview, it was determined that the facility failed to offer influenza vaccines in accordance with facility policy to two of five residents whose vaccines were reviewed. (Residents 18 and 20)Findings include: Review of the facility policy entitled, Influenza Vaccine, last reviewed December 29, 2025, revealed that between October 1 and March 31 each year, the influenza vaccine should be offered to residents, unless the vaccine is medically contraindicated or the resident had already been immunized and the resident (or resident's legal representative) would be provided information and education regarding the benefits and potential side effects of the vaccine. Staff were to document education of the benefit of vaccination, and whether resident received the vaccination or declined in the resident's medical record. Clinical record review revealed that Resident 18 was admitted to the facility on [DATE]. There was no documented evidence that the facility offered an influenza vaccine between October 1, 2025, and March 31, 2026. Clinical record review revealed that Resident 20 was admitted to the facility on [DATE]. There was no documented evidence that the facility offered an influenza vaccine between October 1, 2025, and March 31, 2026. In an interview on May 20, 2026, at 2:20 p.m., the Director of Nursing confirmed that there was no documentation related to influenza vaccines for the identified residents according to the policy. 28 Pa. Code 211.10(d) Resident care policies. 28 Pa. Code 211.12(d)(1)(5) Nursing services. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 395831 | A. Building<br>B. Wing | 05/20/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Schuylkill Center | 1000 Schuylkill Manor Rd<br>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 0887<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 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.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, clinical record review, and staff interview, it was determined that the facility failed to offer COVID-19 vaccines in accordance with facility policy to three of five residents whose vaccines were reviewed. (Residents 4, 20, and 40)Findings include: Review of the facility policy entitled, Coronavirus Disease (COVID-19)-Vaccination of Residents, last reviewed December 29, 2025, revealed that each resident was to be offered the COVID-19 vaccine according to the Centers for Disease Control (CDC) recommendations. Prior to offering the vaccine, the resident was to be provided with education regarding the benefits, risks, and potential side effects associated with the vaccine and the resident was to sign a consent to vaccinate form. Staff were to document education of the benefits and potential risks of vaccination, and whether resident received the vaccination or declined in the resident's medical record. According to the CDC recommendations entitled, COVID-19 Vaccination for Long-term Care Residents, last updated June 11, 2025, the updated 2025-2026 COVID-19 vaccine is recommended for people who live in long term care settings. Clinical record review revealed that Resident 4 was admitted to the facility on [DATE],and was last offered a COVID-19 vaccine in 2024. There was no documented evidence that the facility offered the resident an updated 2025-2026 COVID-19 vaccine. Clinical record review revealed that Resident 20 was admitted to the facility on [DATE], and was last offered a COVID-19 vaccine in 2024. There was no documented evidence that the facility offered the resident an updated 2025-2026 COVID-19 vaccine. Clinical record review revealed that Resident 40 was admitted to the facility on [DATE], and was last offered a COVID-19 vaccine in 2024. There was no documented evidence that the facility offered the resident an updated 2025-2026 COVID-19 vaccine. In an interview on May 20, 2026, at 1:20 p.m., Registered Nurse (RN) 3 confirmed the COVID-19 vaccines were offered yearly. In an interview on May 20, 2026, at 2:20 p.m., the Director of Nursing confirmed that there was no documentation that 2025-2026 COVID-19 vaccines were offered to the identified residents. 28 Pa. Code 211.10(d) Resident care policies.28 Pa. Code 211.12(d)(1)(5) Nursing services. |