STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395853	A. Building B. Wing	04/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Crawford Care Center	20881 State Highway 198 Saegertown, PA 16433

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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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42655 Based on review of facility policy, clinical records, and staff interview, it was determined that the facility failed to ensure a physician's order and POLST (Pennsylvania Orders for Life-Sustaining Treatment) were identical to indicate the correct code status as Full Code (CPR/Attempt Resuscitation) or Do Not Resuscitate (DNR/Do Not Attempt Resuscitation-Allow Natural Death) for one of 18 residents reviewed (Resident R18). Findings include: Facility policy entitled, Communication of Code Status dated [DATE], indicated it is the policy of this facility to adhere to residents' rights to formulate advance directives. In accordance to these rights, this facility will implement procedures to communicate a resident's code status to those individuals who need to know this information. When an order is written pertaining to a resident's presence or absence of an Advance Directive, the directions will be clearly documented in designated sections of the medical record. Examples of directions to be documented include, but are not limited to Full Code, Do Not Resuscitate, Do Not Intubate, Do not Hospitalize. The nurse who notates the physician orders is responsible for documenting the directions in all relevant sections of the medical record. The designated sections of the medical record are ___MISC, POLST _____. The resident's code status will be reviewed at least quarterly and documented in the medical record. Review of Resident R18's clinical record revealed an admitted [DATE], with diagnoses that included Dementia (a disease of the brain that affects decision making, mood, and behaviors), Diabetes Mellitus (a disease affecting how blood sugar is used and regulated throughout the body), Gout (a type of arthritis that causes severe swelling and pain in the joints), and Polyneuropathy (a nerve disorder affecting the nerves from the spinal cord to the skin, muscles, glands, and internal organs). Review of Resident R18's clinical record revealed a physician's order dated [DATE], as Full Code and the POLST dated [DATE], as a DNR. Resident R18's care plan dated [DATE], revealed POLST is Full Code. An interview with the Director of Nursing (DON) confirmed that Resident R18's physician's order is a Full Code, however his/her POLST is a DNR. The DON further confirmed that both the physician's order and the POLST should be identical to ensure Resident R18's wishes are followed in the event of a change in condition and the code status would need to be readily referenced. (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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	28 Pa. Code 201.18 (b)(1) Management 28 Pa. Code 201.18 (e)(1) Management 28 Pa. Code 201.29(a) Resident rights 28 Pa. Code 211.10(a) Resident care policies

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48496 Based on observations, review of facility policies and documents, and staff interviews, it was determined that the facility failed to provide housekeeping services necessary to maintain a clean environment for one of one resident equipment observed (Resident R64). Findings include: Review of facility policy entitled Housekeeping In-Service dated 1/16/25, indicated Dust Mop: The entire floor needs to be dust mopped . and Damp mop: The most important area of a patient's room to disinfect the floor. Review of resident R64's clinical record revealed an admitted [DATE], with diagnoses that included chronic obstructive pulmonary disease (condition when your lungs do not have adequate air flow), anxiety (a condition that causes a person to be nervous, uneasy, or worried about something or someone), and hypertension (high blood pressure). Observations on 4/14/25, at 12:25 p.m., 1:55 p.m., and 2:50 p.m. revealed that upon entering Resident R64's room and walking across the floor, a sticky sound was heard with each step. Further observations of Resident R64's room revealed a large yellow dried liquid substance that appeared to be urine on the floor next to his/her bed. During an interview on 4/14/25, at 2:50 p.m. the Assistant Director of Nursing (ADON) confirmed that the resident's floor was sticky when walking across the room. He/she also confirmed that there was a large yellow dried liquid substance that appeared to be urine on the floor next to Resident R64's bed. He/she confirmed that resident rooms should be kept clean. 28 Pa. Code 201.14 (a) Responsibility of Licensee

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48496 Based on review of facility policy and clinical records, and staff interview, it was determined that the facility failed to provide a written summary of the baseline care plan and order summary to the resident and/or representative for five of 13 residents reviewed (Residents R3, R18, R30, R64, and Closed Record CR110). Findings include: Review of facility policy entitled Baseline Care Plan dated 1/16/25, indicated A written summary of the baseline care plan shall be provided to the resident and representative . and This will be provided by completion of the comprehensive care plan. Review of Resident R3's clinical record revealed an admitted [DATE], with diagnosis that included anxiety (a condition that causes a person to be nervous, uneasy, or worried about something or someone), and hypertension (high blood pressure). Resident R3's clinical record lacked evidence that a written summary of the baseline care plan and order summary was provided to Resident R3 and/or his/her representative. Review of Resident R18's clinical record revealed an admitted [DATE], with diagnoses that included dementia (a disease of the brain that affects decision making, mood, and behaviors), diabetes mellitus (a disease affecting how blood sugar is used and regulated throughout the body), gout (a type of arthritis that causes severe swelling and pain in the joints), and polyneuropathy (a nerve disorder affecting the nerves from the spinal cord to the skin, muscles, glands, and internal organs). Resident R18's clinical record lacked evidence that a written summary of the baseline care plan and order summary was provided to Resident R18 and/or his/her representative. Review of Resident R30's clinical record revealed an admitted [DATE], with diagnoses that included anxiety, obstructive sleep apnea (a condition when a person repeatedly stops and starts breathing when they are sleeping), and hypertension. Resident R30's clinical record lacked evidence that a written summary of the baseline care plan and order summary was provided to Resident R30 and/or his/her representative. Review of Resident R64's clinical record revealed an admitted [DATE], with diagnosis that include chronic obstructive pulmonary disease (condition when your lungs do not have adequate air flow), anxiety, and hypertension. Resident R64's clinical record lacked evidence that a written summary of the baseline care plan and order summary was provided to Resident R64 and/or his/her representative. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident CR110's clinical record revealed an admitted [DATE], with diagnoses that included cellulitis of lower limbs (a bacterial skin infection of lower legs characterized by redness, swelling, and pain), polyneuropathy, diverticulitis (an infection or inflammation in one or more small pouches in the digestive tract), and Radiculopathy (a disease of the root of a nerve, such as from a pinched nerve or a tumor). Resident CR110's clinical record lacked evidence that a written summary of the baseline care plan and order summary was provided to Resident CR110 and/or his/her representative. During an interview on 4/16/25 at 1:30 p.m. the Director of Nursing confirmed that the clinical record of Residents R3, R18, R30, R64, and CR110 lacked evidence that a written summary of the baseline care plan and order summary were provided the resident and/or his/her representative upon admission to the facility. 28 Pa. Code 211.10(c)(d) Resident care policies 28 Pa. Code 201.18 (b)(1) Management

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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** 48496 Based on review of facility policy and clinical records, and staff interview, it was determined that the facility failed to develop a respiratory care plan for two of 25 residents reviewed (Residents R30 and R64). Findings include: Review of facility policy entitled Comprehensive Care Plans dated 1/16/25, indicated The comprehensive care plan will describe . The services that are to be furnished to attain or maintain the residents highest practicable physical, mental, and psychosocial well-being, and The comprehensive care plan will be reviewed and revised . Review of Resident R30's clinical record revealed an admitted [DATE], with diagnoses that included anxiety (a condition that causes a person to be nervous, uneasy, or worried about something or someone), obstructive sleep apnea (a condition when a person repeatedly stops and starts breathing when they are sleeping), and hypertension (high blood pressure). Review of Resident R30's physician's orders revealed an order dated 1/31/25, for oxygen 2 lpm (liters per minute) via nasal cannula (oxygen tubing that has prongs that go into the nostrils and loops around the ears to secure in place to ensure adequate oxygen delivery). Review of Resident R30's care plans revealed no evidence of a care plan for respiratory care and/or oxygen administration. Review of Resident R64's clinical record revealed an admitted [DATE], with diagnoses that include chronic obstructive pulmonary disease (condigion when your lungs do not have adequate air flow), anxiety, and hypertension. Review of Resident R64's physician's orders revealed an order dated 2/10/25, for oxygen at 2 lpm via nasal cannula as needed to keep oxygen saturation above 90%. Review of Resident R64's care plans revealed no evidence of a care plan for respiratory care and/or oxygen administration. During an interview on 4/16/25, at 1:40 p.m. the Registered Nurse Assessment Coordinator confirmed that Residents R30 and R64 lacked care plans regarding oxygen administration. He/she also confirmed that a care plan should have been developed for both Resident R30 and R64's oxygen administration. 28 Pa. Code 211.12(d)(1)(5) Nursing services 28 Pa. Code 211.10(c)(d) Resident care policies

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40832 Based on review of clinical records, observations and staff interviews it was determined that the facility failed to follow the plan of care for one of 25 residents reviewed (Resident R48). Findings include: Resident R48's clinical record revealed an admitted [DATE], with diagnoses including polyosteoarthritis (a form of arthritis that affects multiple joints at the same time), dementia, and dizziness. A care plan entitled Safety/Fall Risk included an intervention dated 8/06/24, to place his/her bed against the wall. Observations on 4/14/25, at 3:05 p.m. and 4/15/25, at 9:52 a.m. revealed Resident R48's bed was positioned with a bedside table between the bed and the wall, and the bed was not placed against the wall as care planned. During an interview on 4/15/25, at 10:20 a.m. Licensed Practical Nurse Employee E5 confirmed that Resident R48's bed was not positioned against the wall. 28 Pa. Code 211.12(d)(5) Nursing services

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40832 Based on review of facility policy and clinical records, observations, and staff interviews, it was determined that the facility failed to provide oxygen according to physician's orders and failed to promote cleanliness and help prevent the spread of infection for four of 25 residents reviewed for respiratory services (Residents R30, R44, R48, and R64). Findings include: A facility policy dated 1/16/25, entitled Oxygen Concentrator revealed the purpose of the policy is to establish responsibilities for the care and use of oxygen concentrators. An oxygen concentrator is a medical device that extracts oxygen from room air by filtering out or separating the nitrogen from the oxygen. The oxygen passes through a filter system and is then stored within the device for delivery based on the flow meter setting. Care of the Concentrator. Filters on concentrators to be cleaned weekly. The main body cabinet should be dusted when needed and can be wiped clean with a damp cloth and mild household cleaner if necessary. Change oxygen tubing and mask/cannula weekly and as needed. Change humidifier bottle when empty, every seventy-two hours . Resident R44's clinical record revealed an admitted [DATE], with diagnoses that included Parkinsonism (a group of brain conditions that cause slowed movements, stiffness, and tremors), vascular dementia (a condition that affects the blood vessels and blood flow of the brain resulting in changes to memory, thinking, and behavior), and chronic obstructive pulmonary disease (COPD - a group of lung diseases that block airflow and make it difficult to breathe). Resident R44's clinical record revealed a physician's order dated 2/08/25, for oxygen at 3 liters per minute (lpm) continuous for COPD. Observations on 4/15/25, at 11:05 a.m. and 4/16/25, at 9:55 a.m. revealed Resident R44 lying in bed with oxygen being delivered via nasal cannula at 3 lpm. The concentrator was observed dusty and with a dried white and brown substance down the front and on the sides. During an interview on 4/17/25, at 10:30 a.m. Licensed Practical Nurse (LPN) Employee E3 confirmed that Resident R44's concentrator filter was missing to the back of the concentrator, the filter inside the concentrator contained a dusty gray substance, and the concentrator itself was dusty with a dried substance noted down the front and sides. LPN Employee E3 further confirmed that the concentrator did not appear to be cleaned weekly and that it was missing a filter. Review of Resident R30's clinical record revealed an admitted [DATE], with diagnosis that include Anxiety (a condition that causes a person to be nervous, uneasy, or worried about something or someone), Obstructive Sleep Apnea (a condition when a person repeatedly stops and starts breathing when they are sleeping), and Hypertension (high blood pressure). Review of Resident R30's physician's orders revealed an order dated 1/31/25, for oxygen 2 lpm via nasal cannula (oxygen tubing that has prongs that go into the nostrils and loops around the ears to secure in place to ensure adequate oxygen delivery). (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observations on 4/14/25, at 12:20 p.m., 1:50 p.m., and 2:50 p.m. revealed Resident R30 lying in bed with oxygen being administered via nasal cannula at 2 lpm. Observation of Resident R30's nasal canula revealed it lacked a date. Further observations revealed a humidification water bottle connected to the oxygen concentrator dated for 4/5/25. Review of resident R64's clinical record revealed an admitted [DATE], with diagnoses that included COPD, anxiety (a condition that causes a person to be nervous, uneasy, or worried about something or someone), and hypertension (high blood pressure). Review of Resident R64's physician's orders revealed an order dated 2/10/25, for oxygen at 2 lpm via nasal cannula as needed to keep oxygen saturation above 90%. Observations on 4/14/25, at 12:25 p.m., 1:55 p.m. and 2:50 p.m. revealed Resident R64 lying in bed with oxygen being administered via nasal cannula at 2 lpm. Observation of Resident R64's nasal canula revealed it lacked a date. Further observations revealed a humidification water bottle connected to the oxygen concentrator dated for 4/6/25. During an interview on 4/14/25, at 2:50 p.m. the Assistant Director of Nursing (ADON) confirmed that the date on Resident R30's humidification water bottle was 4/5/25, and the date on Resident R64's humidification water bottle was 4/6/25. He/she confirmed that Resident R30 and Resident R64's nasal cannulas were lacking a date. He/she also confirmed that the humidification water bottles and the nasal cannulas should be changed weekly. Resident R48's clinical record revealed an admitted [DATE], with diagnoses that included polyosteoarthritis (a form of arthritis that affects multiple joints at the same time), dementia, and dizziness. Observation on 4/14/25, at 3:05 p.m. revealed a nebulizer (small machine that turns liquid medicine into a mist that can be easily inhaled) with a mask dated 3/15/25, in Resident R48's room. Resident R48 confirmed that he/she was not aware it was laying on his table stand and does not remember having one. Further review of Resident R48's clinical record lacked evidence of a physcian's order and/or a care plan for a nebulizer, and there was no evidence in his/her departmental progress notes (3/14/25, to present) of requiring a nebulizer. During an interview on 4/15/25, at 10:27 a.m. LPN Employee E5 confirmed the nebulizer machine on Resident R48's stand was dated for 3/15/25, and that there was no current order for the nebulizer and that he/she does not ever remember Resident R48 having them ordered. 28 Pa. Code 211.12(d)(1)(5) Nursing services 28 Pa. Code 211.10(c) Resident care policies

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that the resident and his/her doctor meet face-to-face at all required visits. 48496 Based on review of clinical records and resident and staff interviews, it was determined that the facility failed to ensure that physician visits were conducted at least once every 60 days for three of three residents reviewed (R15, R19, and R26). Findings include: Interview on 4/15/25, at 1:35 p.m. with Resident R15 revealed that he/she had not seen their physician since his/her prior physician had stopped coming to the facility. He/she expressed that he/she has only seen the nurse practitioner. Interview on 4/15/25, at 2:00 p.m. with Resident R19 revealed that he/she has only seen a nurse practitioner since their last physician stopped coming to the facility, which was sometime last summer. Interview on 4/14/25, at 12:15 p.m. with Resident R26 revealed that he/she has not seen their physician since his/her prior physician stopped coming to the facility. He/she expressed that the last time they saw their physician was sometime last summer. He/she expressed that they have only seen the nurse practitioner. Interviews on 4/15/25, at 2:00 p.m. during resident council meeting revealed four out of five residents attending expressed that they have not seen a physician since their previous physician stopped coming to the facility. They also expressed that they have only seen a nurse practitioner. Review of Resident R15's clinical record revealed a physician note dated 7/18/24, from resident's previous physician. The resident's clinical record lacked evidence of physician visits between August 2024 through December 2024. Further review revealed physician notes from 1/16/25, 3/13/25, and 4/10/25. All three visit notes were signed by both the nurse practitioner and the physician. The physician notes were not clear definitely as to who actually saw Resident R15. Review of Resident R19's clinical record revealed a physician note from 7/18/24, from resident's previous physician. The resident's clinical record lacked evidence of physician visits between August 2024 through December 2024. Further review revealed physician notes from 1/16/25, 3/13/25, and 3/26/25. All three visit notes were signed by both the nurse practitioner and the physician. The physician notes were not clear definitely as to who actually saw Resident R19. Review of Resident R26's clinical record revealed a physician note from 7/18/24, from resident's previous physician. Resident's clinical record lacked evidence of physician visits between August 2024 through December 2024. Further review revealed physician notes from 1/16/25, 2/20/25, 3/20/25, and 4/3/25. All four visit notes were signed by both the nurse practitioner and the physician. The physician notes were not clear definitely as to who actually saw Resident R26. (continued on next page)

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/17/25, at 1:00 p.m. the Assistant Director of Nursing (ADON) confirmed that the physician and the nurse practitioner come to the facility for visits on different days. The ADON also confirmed that there was no evidence of who made visits on the dates on the physician visit's documentation and that Resident R15, R19, and R26's clinical records had no evidence that they were definitely seen by their physician between August 2024 and December 2024. He/she also confirmed that all residents should be seen by their physician every 60 days. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18(b)(1)(3) Management 28 Pa. Code 211.5(f)(ii)(vii) Medical records

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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. 48496 Based on review of facility policy and manufacturer's guidelines, observations and staff interviews, it was determined that the facility failed to appropriately discard outdated medications for one of three medication carts reviewed and one of two medication rooms reviewed (500 and 100 hall medication carts and 500/600 medication room). Findings include: Review of facility policy entitled Multi-Dose Vials dated 1/16/25, indicated Multi-dose vials will be labeled with date open. Medications will be discarded . Insulin is 28 days from date open. Review of manufacturer's guidelines revealed that an open pen of Lispro Insulin must be used within 28 days after opening or be discarded. Review of manufacturer's guidelines revealed that an open pen of Lantus/Basaglar Insulin must be used within 28 days after opening or be discarded, even if the vial still contains insulin. Review of manufacturer's guidelines revealed that an open vial of Tubersol (solution to test for tuberculosis) should be discarded within 30 days after opening. Observation of drug storage on 4/14/25, at 12:40 p.m. of the 500 hall medication cart revealed an open Lispro Insulin pen, an open Basaglar Insulin pen, and an open Lantus Insulin pen with no dates indicating when the insulin pens were open. During an interview on 4/14/25, at the time of observation with Licensed Practical Nurse (LPN) Employee E1, he/she confirmed that the open Lispro, Basaglar, and Lantus insulin pens lacked open dates, and staff were unable to determine the discard date. He/she also confirmed that the insulin pens should have been discarded. Observation of drug storage on 4/14/25, at 12:45 p.m. of the 100 hall medication cart revealed an open Lantus Insulin pen with no date indicating when the insulin pen was open. During an interview on 4/14/25, at the time of observation with LPN Employee E2, he/she confirmed that the open Lantus Insulin pen lacked an open date, and staff were unable to determine the discard date. He/she also confirmed that the insulin pen should have been discarded. Observation of drug storage on 4/14/25, at 12:50 p.m. of the 500/600 medication room revealed an opened vial of Tubersol with no date indicating when the vial was open. During an interview on 4/14/25, at the time of observation with LPN Employee E1, he/she confirmed that the open vial of Tubersol lacked an open date, and staff were unable to determine the discard date. He/she also confirmed that the vial of Tubersol should have been discarded. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395853	A. Building B. Wing	04/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Crawford Care Center	20881 State Highway 198 Saegertown, PA 16433

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	28 Pa. Code 201.18(b)(1) Management 28 Pa. Code 211.9(a)(1) Pharmacy services 28 Pa. Code 211.12(d)(1) Nursing services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395853	A. Building B. Wing	04/17/2025

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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. 40832 Based on observations, review of facility policies and International Plumbing Code, and staff interviews it was determined that the facility failed to safely store food containers, and prepare, serve and store food in a safe and sanitary manner in the main kitchen; failed to prevent the potential for cross contamination (transfer of harmful substances or disease-causing organisms to food from unclean hands or objects) during food preparation; and failed to maintain safe storage of ice for residents for one of one ice machines located in the kitchen. Findings include: Review of the International Plumbing Code Chapter Eight dated 2018, revealed that devices that store ice and that discharge to the drainage system shall be provided with protection against backflow, flooding, fouling, contamination and stoppage of the drain; and when equipment discharges potable clear water waste (fit for human consumption) to the building drainage system, the discharge shall be through an indirect pipe by means of an air gap. A facility policy entitled Equipment dated 1/16/25, indicated that all equipment will be routinely cleaned and maintained in accordance with manufacturer's directions and training materials; all food contact equipment will be cleaned and sanitized after every use; and all non-foods contact equipment will be clean and free of debris. A facility policy entitled Food Storage: Cold Foods dated 1/16/25, indicated that all foods will be stored wrapped or in covered containers, labeled and dated, and arranged in a manner to prevent cross contamination. A facility policy entitled Food Storage: Dry Goods dated 1/16/25, indicated that all packaged and canned food items will be kept clean, dry, and properly sealed. Observations on 4/14/25, at 10:55 a.m. and 12:21 p.m. of the facility main kitchen revealed: -A clear plastic square container with an orange/red liquid in the cooler and was not labeled and/or dated. -The drain hose leading from the ice machine storage bin to the floor drain lacked the required air gap between the hose and the floor drain, and the side of ice machine was splattered with dried food. -There was wet stacking and food crumbs between stored metal steam table inserts. -Opened and unsealed bags of sugar and flour on the bottom shelf in the dry storage area. -Food crumbs in the bottom of the clean utensil storage bins. (continued on next page)

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	395853	A. Building B. Wing	04/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Crawford Care Center	20881 State Highway 198 Saegertown, PA 16433

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-Dietary staff rolling silverware in paper napkins without gloves and touched eating end of the silverware when transferring items from the dishwasher basket to the utensil tray. -The floor of two ovens inside were covered in black substance, scattered with moderate amount of food pieces and crumbs. During interviews on 4/14/25, at 10:55 a.m. and 12:21 p.m. the Dietary Manager confirmed that all opened food items should have a date and be sealed properly; equipment should be cleaned between uses; pans should not be stored/stacked wet and food crumbs should be cleaned up; staff should not touch silverware/clean eating surface with bare hands; ovens should be cleaned regularly; and there should be an air gap between the drain hose of the ice machine and floor drain. Interview on 4/14/25, at 3:30 p.m. with the Dietary Manager also confirmed there was no schedule for cleaning of kitchen appliances. Interview on 4/15/25, at 11:00 a.m. with the Director of Operations in Dietary confirmed there should be an air gap between the ice machine storage bin's drainage hose and the floor drain to prevent organism transfer from the floor and/or drain pipes to the ice machine drain hose. 28 Pa. Code 211.6(f) Dietary services 28 Pa. Code 201.18(b)(1) Management 28 Pa. Code 201.14(a) Responsibility of licensee

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395853	A. Building B. Wing	04/17/2025

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Dispose of garbage and refuse properly. 40832 Based on review of facility policy, observation and staff interview, it was determined that the facility failed to ensure that waste was properly contained in dumpsters or compactors with lids or otherwise covered, and the garbage storage area was maintained in a sanitary condition to prevent the potential of harborage and feeding of pests for one of one garbage storage areas. Findings include: A facility policy entitled Disposal of Garbage and Refuse dated 1/16/25, indicated that refuse containers and dumpsters kept outside the facility shall be designed and constructed to have tightly fitting lids, doors, or cover; containers and dumpsters shall be kept covered when not being loaded; dumpsters shall be emptied according to the facility contract and garbage should not accumulate or be left outside the dumpster. Observation on 4/14/25, at 1:35 p.m. revealed four plastic rolling carts in proximity of the facility loading dock were overflowing with garbage bags. Three of the plastic carts contained clear unsealed garbage bags of cans with food remaining in a number the cans, and one plastic cart contained black and clear bags of garbage with dietary and housekeeping waste. During an interview on 4/14/25, at 2:02 p.m. the Director of Maintenance and the Nursing Home Administrator confirmed that the cart of dietary and housekeeping garbage was more than one days' worth, and that the bags containing the cans should have been loaded into the dumpster and not left sitting by the dock. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18(b)(1)(3) Management