STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	396137	A. Building B. Wing	05/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Athens Nursing and Rehabilitation Center	200 South Main St Athens, PA 18810

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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 observation and staff interview, it was determined that the facility failed to store food and maintain food service equipment in accordance with professional standards for food service safety in the facility's main kitchen, and one of two nursing units (Sage). Findings include: An observation in the facility's main kitchen on May 18, 2026, at 10:15 AM with Employee 19, kitchen manager, revealed the following: The refrigerator referred to as the cook's fridge had a container of onions and peppers, tomato soup, and a turkey roast that were dated May 11, 2026. A rack containing loaves of bread and bags of buns had no receive date or expiration date on the bags. Employee 19 confirmed that the bags had been removed from the freezer but had not been dated. The dishwasher unit had a metal box located under the unit that Employee 19 believed was a contained heating element which had a thermal tape coating noted to be bubbling and peeling from around the unit. An observation on May 20, 2026, at 9:15 AM of the panty located on Sage unit revealed the following: The counter around the sink had areas of dried brown liquid, and the left side of the wooden cupboard containing the sink was bulging, and the finish appeared to be rippled from contact with water. The wall above the sink had a dried brown and a dried red splashed substance noted near the ceiling. The condiment tray had an open container of sugar free breakfast syrup with a saturated pepper packet stuck to it and crystalized syrup noted in the condiment tray. The refrigerator had a bag of grapes dated May 9, 2026, that contained grapes that were brown and wrinkled. The top of the refrigerator was covered in dust. The ice machine drainage tube was looped and contained a black substance visible through the clear tubing. The end of the tube appeared to enter a red container, and no drain or air gap could be visualized. Behind the ice machine was a Styrofoam cup full of water from what appeared to be a water leak in a tube behind the machine. The cup was sitting on two wooden pieces of two by four which ran along the wall and appeared to be wet. A plastic spoon and a plastic lid were visible under the ice machine. The above information was reviewed with the Nursing Home Administrator on May 21, 2026, at 12:00 PM. 483.60(i)(2) Store, prepare, food safe and sanitaryPreviously cited 7/3/25 28 Pa. Code 201.14 (a) Responsibility of Licensee

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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on a review of select facility policies and procedures, clinical record review, and staff interview, it was determined that the facility failed to ensure residents' medication regime was free from potentially unnecessary medications for two of five residents reviewed for medication regimen review (Residents 2 and 10). Findings include: The facility policy entitled, Psychotropic Medication Use, last reviewed without changes on April 1, 2026, revealed that medications in the following categories are considered psychotropic medications and are subject to prescribing, monitoring, and review requirements specific to psychotropic medications: antipsychotics, antidepressants, antianxiety medications; and hypnotic/sedatives. Psychotropic medication management is an interdisciplinary process that involves the resident, family, and/or the representative and includes: determining adequate indications for use, adequate monitoring for efficacy and adverse consequences, determining appropriateness of gradual dose reductions, and preventing/identifying/responding to adverse consequences. When determining whether to initiate, modify, or discontinue medication therapy, the interdisciplinary team conducts and documents an evaluation of the resident. The evaluation includes the resident's: physical, behavioral, mental, and psychosocial status; expressions or indications of distress; and resident behaviors and symptoms. Monitoring may include lab results, vital signs, progress notes, behavior flow sheets, medication administration records, and the drug regimen review from the consultant pharmacist. In addition, residents are monitored for adverse consequences associated with psychotropic medications. Clinical record review for Resident 2 revealed that the facility admitted him on July 10, 2025. A review of his medication regime revealed revisions of his physician's orders for the use of the antidepressant, Fluoxetine (Prozac): Fluoxetine 40 mg (milligrams) one time a day for depression, discontinued August 5, 2025Fluoxetine 20 mg one time a day for depression from August 6, 2025, to September 9, 2025Fluoxetine 40 mg one time a day for depression from September 10, 2025, to February 16, 2026Fluoxetine 60 mg one time a day for depression from February 17, 2026 to April 8, 2026Fluoxetine 40 mg one time a day for depression from April 9, 2026, to the dates of the onsite visit beginning May 18, 2026 Physician progress note documentation dated March 3, 2026, at 10:48 AM revealed that Resident 2 stated that he had a tremor that sometimes limits his ability to shave and hold his cup. The documentation indicated that Resident 2's Fluoxetine dose increased to 60 mg per the contracted psych provider (Resident 2 previously was prescribed 20 mg). Nursing documentation dated March 16, 2026, at 12:56 PM revealed that the contracted psych nurse practitioner assessed Resident 2 for anxiety and depression and recommended to continue the current dose of Prozac (Fluoxetine). Physician progress note documentation dated April 2, 2026, at 10:21 AM revealed that Resident 2 stated that he had a tremor that sometimes limits his ability to shave and hold his cup and that communication to the contracted psych provider questioned if Resident 2's Fluoxetine could be reduced in view of the reported increased tremor. Progress note documentation by the facility's contracted psychiatry provider dated April 6, 2026, confirmed that there was a concern noted about an increase in Resident 2's tremors and that it may be related to the Prozac titration or his Gabapentin (Neurontin, medication used to treat the symptoms of neuropathy/abnormal sensations or pain from nerve damage). Prozac was titrated from 40 mg to 60 mg on a February 9, 2026, visit. Resident 2 was agreeable to go back to the 40 mg dose to reduce the chance of tremors returning. The provider indicated that Resident 2, .seems he likes things a certain way and when this doesn't happen, he becomes passive aggressive in a sense. Social services documentation dated April 28, 2026, at 11:25 AM revealed that Resident 2 had a PHQ-9 (scoring system that ranges from zero to 27, with higher scores indicating more severe depression symptoms) severity score of 24, indicating severe depression. He also related that he felt that he would be better off dead every day. Resident 2 reported that he felt, extra depressed, due to a recent fall, fracture, surgery, and hospitalization. He (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	had a significant history for depression and anxiety and received Fluoxetine and is followed by psych services for medication management. Social services would continue to follow for psychosocial needs. Social services documentation dated April 28, 2026, at 12:42 PM indicated that Resident 2's PHQ-9 severity score was 27, not 24. Physician progress note documentation dated May 18, 2026, at 10:57 AM revealed that Resident 2 stated that he had a tremor and that communication to the contracted psych provider questioned if Resident 2's Fluoxetine could be reduced in view of the reported increased tremor. Review of a plan of care developed by the facility (initiated July 21, 2025) to address Resident 2's risk for alteration in mood state related to admission and history of depression and anxiety revealed interventions that included to, Observe for/document/report to MD s/sx (signs and symptoms) of depression, including: hopelessness, anxiety, sadness, insomnia, anorexia, verbalizing, negative statements, repetitive anxious or health-related complaints, tearfulness. Interview with the Nursing Home Administrator and Director of Nursing on May 21, 2026, at 8:15 AM revealed that staff document ongoing monitoring of negative behaviors and potential medication adverse side effects on the MAR/TAR (medication administration record/treatment administration record, electronic documentation by licensed staff). Review of Resident 2's MAR/TAR dated March, April, and May 2026 revealed no ongoing monitoring of negative behaviors related to his depression diagnosis or potential adverse side effects from the use of the antidepressant medication. Resident 2's medication regimen included the use of an antidepressant without adequate monitoring of behavioral symptoms and potential adverse side effects. Clinical record review revealed the facility admitted Resident 10 on November 7, 2024. Review of Resident 10's active physician orders revealed staff are to administer the following psychotropic medications: Sertraline HCl (an antidepressant medication) 100 mg, one tablet every evening and night shift.Sertraline HCl 25 mg, one tablet at bedtime.Trazodone HCl (an antidepressant medication) 50 mg, one tablet every evening.Risperdal (an antipsychotic medication) 3 mg, two times a day. The facility-initiated behavior monitoring November 7, 2024, combining Resident 10's behaviors of anxiety and aggressiveness. Review of Resident 10's MAR/TAR dated March, April, and May 2026 revealed no ongoing monitoring of negative behaviors related to her depression diagnosis. Resident 10's medication regimen included the use of antipsychotic and antidepressant medications without adequate monitoring of behavioral symptoms. The above findings for Resident 10 were confirmed with the Director of Nursing on May 20, 2026, at 10:46 AM. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, observation, and resident and staff interviews, it was determined that the facility failed to provide the highest practicable care regarding physician ordered interventions for three of 18 residents reviewed (Residents 3, 5, and 30). Findings include: Clinical record review for Resident 30 revealed an active physician order dated February 6, 2026, for Resident 30 to wear tubigrips (elastic tubular bandage designed to provide moderate compression and support to reduce swelling in limbs) to his bilateral lower extremities every day. Review of Resident 30's plans of care developed by the facility to address his care needs revealed no intervention that included the use of tubigrips daily to his bilateral lower extremities. Review of Resident 30's MAR/TAR (Medication Administration Record/Treatment Administration Record, electronic documentation completed by licensed nursing staff for the completion of care) dated May 2026 revealed that staff initialed the application of the tubigrips in the morning. Observation of Resident 30 on May 19, 2026, at 10:22 AM revealed that his bilateral lower legs and ankles were swollen and he did not have any compression garments in place to his legs. Interview with Resident 30 on the date and time of the observation indicated that he did not know if he was to wear compression garments on his legs. Observation of Resident 30 on May 21, 2026, at 9:40 AM with Employee 1 (licensed practical nurse) revealed that Resident 30 did not have tubigrips on his bilateral lower extremities; and his lower legs and ankles presented with swelling. Resident 30 stated he was not wearing any compression on his lower extremities because, I didn't get them yet. The surveyor reviewed the above concerns regarding Resident 30's physician ordered tubigrips during an interview with the Nursing Home Administrator and the Director of Nursing on May 21, 2026, at 11:08 AM. Observation of Resident 5 on May 18, 2026, at 12:23 PM revealed that his bilateral lower extremities presented with ace wraps that were intact on his left lower extremity but were unwinding and rolled on his right lower extremity. Interview with Resident 5 on the date and time of the observation revealed that he reported that staff do not remove the ace wraps daily. Resident 5 could not report when staff last removed his ace wraps. Documentation by the facility's contracted podiatry provider dated February 5, 2026, and April 7, 2026, noted that Resident 5 had absent dorsalis (top of the foot) and posterior tibial (behind and slightly below the ankle bone) pulses and nail thickening on both feet. The documentation dated April 7, 2026, noted that Resident 5 had a callus (thickened/hardened skin), dry skin, and lower extremity edema (swelling). The documentation included, consult with PCP (primary care physician) regarding diuretics (medication used to rid the body of excess fluids) and compression therapy to reduce LE (lower extremity) edema in an attempt to prevent skin breakdown. Clinical record review for Resident 5 revealed no physician order for the use of ace wraps to his bilateral lower extremities. Review of a plan of care initiated by the facility on July 1, 2025, identified that Resident 5 had pain and decreased circulation related to a diagnosis of peripheral vascular disease (a condition characterized by narrowing, blockage, or spasming of blood vessels most commonly affecting the legs). The plan of care did not include the application of ace wraps to his legs. The surveyor reviewed the above concern that Resident 5 had bilateral lower extremity ace wraps in place without a physician's order during an interview with the Nursing Home Administrator and the Director of Nursing on May 19, 2026, at 3:00 PM. Clinical record review revealed the facility admitted Resident 3 on September 3, 2025, with diagnosis including chronic congestive heart failure and chronic kidney disease. A physician order dated October 22, 2025, revealed Resident 3 was ordered to be on a 1500 milliliter (ml) fluid restriction every 24 hours as follows: dietary department 1080 ml on meal trays (breakfast 360 ml, lunch 360 ml, and dinner 360 ml), and nursing department 420 ml (first shift 180 ml, second shift 150 ml, and night shift 90 ml) and staff are to document all fluid intakes in point of care (POC) fluid intake task. During an interview with Resident 3 on May 18, 2026, at 11:47 AM he stated that he is on a fluid restriction. Observation of Resident 3's room at this time revealed he had four cases of water on the (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	floor beside his recliner; two empty plastic water bottles were observed in his trash can. Further observation and interview with Resident 3 on May 21, 2026, at 11:46 AM revealed two empty soda bottles, and an empty white Styrofoam cup on his overbed table. Resident 3 stated that he gets cases of water delivered and staff do not monitor the amount of personal water he drinks daily. Review of POC documentation of Resident 3's fluid intakes from May 18 to 20, 2026, revealed the following totals:May 18, 2026- 1950 cc/mlMay 19, 2026- 1920 cc/mlMay 20, 2026- 1800 cc/ml Review of Resident 3's most recent nutritional risk assessment dated [DATE], confirmed he is ordered a 1500 mL fluid restriction, but did not address Resident 3 not complying with his fluid restriction. There was no documentation that facility staff addressed Resident 3's noncompliance with his fluid restriction, educating Resident 3 of the possible outcomes of not complying. The above findings for Resident 3 were reviewed with the Nursing Home Administrator and Director of Nursing on May 21, 2026, at 12:19 PM. 483.25 Quality of CarePreviously cited 7/3/25 28 Pa. Code 211.12(c)(d)(1)(3)(5) Nursing Services

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. **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 develop and implement individualized person-centered care plans to address dementia and cognitive loss displayed by two of two residents reviewed (Residents 10 and 74).Findings include: Clinical record review for Resident 74 revealed the facility admitted her on August 27, 2025, with diagnoses including dementia (loss of memory, language, problem-solving, and other thinking abilities that interfere with daily life). A review of Resident 74's admission Minimum Data Set Assessment (MDS, a form completed at specific intervals to determine care needs) dated August 29, 2025, indicated that the facility assessed Resident 74 as having a diagnosis of dementia. The facility determined that a care plan for dementia and cognitive loss would be developed. A review of Resident 74's care plan revealed that there was no indication that the facility had developed and implemented a person-centered care plan to address the resident's dementia and cognitive loss. Clinical record review for Resident 10 revealed the facility admitted her on November 7, 2024, with diagnosis including dementia. Review of Resident 10's annual MDS dated [DATE], indicated that the facility assessed Resident 10 as having a diagnosis of dementia. The facility determined that a care plan for dementia and cognitive loss would be developed. A review of Resident 10's care plan revealed that there was no indication that the facility had developed and implemented a person-centered care plan to address the resident's dementia and cognitive loss. Interview with Employee 15 (social worker) on May 20, 2026, at 9:02 AM confirmed these findings. The findings were reviewed with the Director of Nursing on May 21, 2026, at 11:50 AM, and she was unable to provide any further documentation indicating the facility developed and implemented individualized person-centered care plans to address Residents 10 and 74's dementia and cognitive loss 28 Pa Code 211.12 (d)(1)(3)(5) Nursing service

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on review of select facility policies and procedures, observation, clinical record review, and resident and staff interview, it was determined that the facility failed to implement appropriate transmission-based precautions (TBP) for two of three residents reviewed on TBP (Residents 35 and 69), failed to implement Enhanced Barrier Precautions for one of 18 residents reviewed (Resident 2), failed to implement measures to ensure hygienically cleaned laundry in the laundry department, failed to ensure an environment free from the potential spread of infection related to hand hygiene for one of 18 residents reviewed (Resident 81) and in the facility laundry department, and failed to implement an effective Water Management Program for the prevention and control of water-borne contaminants, such as Legionella (a bacteria that may cause Legionnaires' Disease, a serious type of pneumonia). Findings include: Clinical record review for Resident 2 revealed an active physician's order dated April 29, 2026, for staff to implement Enhanced Barrier Precautions (EBP, use gown and gloves for high contact resident care including dressing, bathing, showering, transfers, hygiene care, assisted toileting, perineal care, wound care and care of any device) every shift for surgical incision. Interview with Resident 2 on May 18, 2026, at 11:44 AM revealed that he had recent back surgery and had a surgical incision on his back. Observation of Resident 2's room door on the date and time of the interview revealed a sign that alerted staff and visitors of the EBP required for the room and a yellow organizer on the door that held personal protective equipment (PPE) such as gloves and gowns. During the interaction with Resident 2, he requested that Employee 2 (licensed practical nurse) remove his surgical wound dressing for the surveyor to observe his back incision. Employee 2 obtained gloves and removed the dressing from Resident 2's back incision. Employee 2 did not don a gown before removing the dressing. Employee 2 stated that she needed to leave the room to obtain supplies to reapply the dry dressing to Resident 2's back. Employee 2 removed her gloves and performed hand hygiene, left the room, obtained dressing supplies, donned gloves, entered Resident 2's room, and reapplied a dry dressing to Resident 2's surgical wound site. Employee 2 did not don a gown for the high contact care with the surgical wound area. The surveyor reviewed the concerns regarding the implementation of EBP for Resident 2 during an interview with the Nursing Home Administrator and the Director of Nursing on May 19, 2026, at 3:00 PM. The facility policy entitled, Handwashing/Hand Hygiene, last reviewed without changes on April 1, 2026, revealed that all personnel are trained and regularly in-serviced on the importance of hand hygiene in preventing the transmission of healthcare-associated infections. Hand hygiene products and supplies (sinks, soap, towels, alcohol-based hand rub, etc.) are readily accessible and convenient for staff use to encourage compliance with hand hygiene policies. Alcohol-based hand rub dispensers are placed in areas of high visibility and consistent with workflow throughout the facility. Hand hygiene is indicated after touching a resident or the resident's environment, before applying non-sterile gloves, and immediately after glove removal. Observation of a medication administration pass on May 19, 2026, at 9:08 AM revealed Employee 1 (licensed practical nurse) administer medication to Resident 81. After Employee 1 prepared the medications for Resident 81 with gloved hands, she removed her gloves, locked the medication cart, and donned new gloves. Employee 1 did not perform hand hygiene between glove changes. After Resident 81 took his medication on May 19, 2026, at 9:10 AM Employee 1 removed her gloves and began documenting the administration of medications on the medication cart computer. Employee 1 did not perform hand hygiene after removing her gloves. Interview with Employee 1 on May 19, 2026, at 9:12 AM confirmed that she had received handwashing education, but she could not recall the hand hygiene required between glove changes. The surveyor reviewed the above hand hygiene concerns during an interview with the Director of Nursing and the Nursing Home Administrator on May 19, 2026, at 3:00 PM. Observation of the facility's main laundry department on May 21, 2026, at 9:03 AM with Employee 13 (housekeeper/laundry aide) revealed that soiled resident personal laundry is sorted in the soiled laundry room and brought to another room that contained two washers (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	and two dryers. The bags of soiled laundry are opened in front of and emptied into the washers, staff remove their gloves, leave that room, go to a bathroom in the hallway approximately 20 feet away, and wash their hands. Employee 13 stated that the sink (that was covered with a clear board) near the facility washers did not function for at least the two months that she worked in the laundry/housekeeping department. Employee 13 also stated that she was unaware of how staff ensure that the washers are not filled above their manufacturer's stated capacity to ensure appropriate agitation during processing; she did not know the load weight capacity of the washers. Employee 13 obtained assistance from her supervisor, Employee 14 (maintenance director) on May 21, 2026, at 9:19 AM, who stated that each facility washer has a weight capacity of 21.5 pounds; and that the facility had a scale to weigh soiled laundry loads before processing. Observation of the soiled laundry room with Employees 13 and 14 on May 21, 2026, at 9:22 AM revealed a laundry scale in the corner of the room that contained two brooms and a dustpan. The scale appeared unused for recent laundry processing. Interview with Employee 14 on May 21, 2026, at 9:22 AM revealed that he was not aware that the sink near the facility washers was not functioning. After the staff removed the clear board that covered the sink, it was determined that both the hot and cold-water supply worked. The surveyor reviewed the above laundry department concerns during an interview with the Nursing Home Administrator and the Director of Nursing on May 21, 2026, at 11:08 AM. The surveyor requested the facility's waterborne pathogen prevention program to mitigate waterborne illness (such as Legionella) risk during a facility entrance interview on May 18, 2026, at 10:30 AM. During an interview with the Director of Nursing and the Nursing Home Administrator on May 19, 2026, at 3:00 PM the facility provided the CDC (U.S. Centers for Disease Control and Prevention) Healthcare Facility Water Management Program Checklist that was not individualized for the facility; but was the outline suggested by CDC to follow to formulate an individualized facility water management program. Interview with Employee 14 (maintenance director) and the Nursing Home Administrator on May 20, 2026, at 9:00 AM revealed that the facility reported they had no water holding tanks and that city water entered the building and to hot water heaters directly. The facility did not provide a schematic of the building that identified potential problem areas or a waterborne pathogen prevention program that included identified risks, control measures to prevent growth of pathogens, protocols to monitor the measures, acceptable monitoring outcomes, and established methods to intervene when control measures are not met. Interview with Employee 14 on May 20, 2026, at 11:55 AM revealed that the available facility Legionella Surveillance and Detection and Legionella Water Management Program policies indicate that areas in the water system that could encourage the growth and spread of Legionella or other waterborne bacteria include water storage tanks, water heaters, filters, fountains, etc.; however, the program did not stipulate specific measures to control the introduction and/or spread of Legionella, the control limits that are acceptable and are monitored, or a plan for when control limits are not met or effective. The facility failed to develop and implement measures to minimize the risk of Legionella and other opportunistic pathogens in the building's water systems through a documented water management program based on nationally accepted standards. Clinical record review for Resident 69 revealed that they tested positive for MRSA (Methicillin-resistant Staphylococcus aureus, a multi-drug-resistant organism, or MDRO) to an open area located on their abdomen and was subsequently placed on contact precautions (additional infection control measures used to prevent the spread of infectious diseases, also referred to as Transmission Based Precautions or TBP), by the provider on May 11, 2026. Observation of Resident 69's room on May 18, 2026, at 11:25 AM revealed signage outside the resident's door, which indicated contact precautions were in place for the room, and everyone must clean hands before entering and when exiting the room, and all staff and providers must wear a gown and gloves before entering the room, and remove them before exiting. Supplies including gowns and gloves were noted to be hanging on the door. Observation on May 18, 2026, at 11:55 AM revealed Employee 16, nurse aide, deliver Resident 69's meal tray without putting on gloves or a gown. Clinical record review for Resident 35 revealed a (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	diagnosis for Clostridium Difficile (a bacterial infection, also referred to as C. Difficile) entered on April 1, 2026. Further review revealed the resident was on contact precautions. Facility Policy titled Clostridioides (Clostridium) Difficile last updated on April 1, 2026, revealed that it is the facility policy to implement steps toward prevention and early intervention which include frequent hand washing with soap and water by staff and residents, wearing gloves and a gown when caring for residents with potential infectious diarrheas, or when handling feces or articles contaminated with feces. Observation of Resident 35's room on May 18, 2026, at 3:00 PM revealed signage outside the resident's door, which indicated contact precautions were in place for the room, everyone must clean hands before entering and when exiting the room, and all staff and providers must wear a gown and gloves before entering the room and remove them before exiting. Supplies including gowns and gloves were noted to be hanging on the door. The door to the room was open with a privacy curtain pulled around the resident. Employee 7, registered nurse, was observed in the room providing care for Resident 35. Employee 7 was observed exiting the room with gloves on their hands holding unbagged laundry in their right hand, and a handful of supplies in their left hand, which appeared to be prefilled syringes. Employee 7 took the dirty laundry to the dirty linen room across from the nursing station on Ivy unit and then placed the handful of supplies on the nursing counter while speaking with other staff. Employee 7 then returned to Resident 35's room with the supplies and entered the room without washing hands or applying a gown and clean gloves. Employee 7 continued to provide care for Resident 35, while Employee 8, nurse aide, entered the room to assist Employee 7. Employee 8 was not observed washing their hands and did not put on a gown before entering the room. At 3:15 PM, Employee 7 exited the room without washing hands. Employee 7, with gloves remaining on hands, was holding pillowcases and two pillows that were not in a plastic bag and took them to the dirty linen room. At this time, Employee 7 was heard requesting a Hoyer Lift (a specific style of lift that is used to transfer patients with limited mobility from one location to another). Employee 7 then entered Resident 35's room again and did not wash their hands or put a gown or clean gloves on. At 3:25 PM Employee 9, nurse aide, entered Resident 35's room with a Hoyer Lift and was observed taking it to resident 35's bedside. Employee 9 did not put on a gown or gloves prior to entering the resident's room. At this, employee 9 then closed Resident 35's door. The Nursing Home administrator and the director of nursing were made aware of the above concerns related to Resident 69 and Resident 35 on May 19, 2026, at 3:00 PM. Observation on May 21, 2026, at 11:05 AM, revealed that there was no garbage disposal bin for gloves or gowns when exiting Resident 35's room. Employee 1, licensed practical nurse, and Employee 11, nurse aide, stated that the gowns and gloves were just being disposed of in the resident's personal trash bins. Employee 1, and Employee 11 stated that to their knowledge there have never been any trash bins to dispose of gowns gloves, or linens located in the room. During an interview on May 21, 2026, at 11:35 AM with the Nursing Home Administrator and the Director of Nursing, the Director of Nursing indicated that they did have a shortage of disposal bins. 483.80 Infection ControlPreviously cited deficiency 7/3/25 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18(b)(1) Management 28 Pa. Code 211.10(d) Resident care policies 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	396137	A. Building B. Wing	05/21/2026

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of select facility policies and procedures, clinical record review, and staff interview, it was determined that the facility failed to ensure residents were offered the pneumococcal immunization unless contraindicated for three of five residents reviewed for immunizations (Residents 22, 30, and 54).Findings include: The facility policy entitled, Pneumococcal Vaccine, last reviewed without changes on April 1, 2026, revealed that all residents will be offered pneumococcal vaccines to aid in preventing pneumonia/pneumococcal infections. Prior to or upon admission, residents will be assessed for eligibility to receive the pneumococcal vaccine and, when indicated, will be offered the vaccine series within 30 days of admission unless medically contraindicated. Administration of the pneumococcal vaccines or revaccinations will be made in accordance with current Centers for Disease Control and Prevention (CDC) recommendations at the time of the vaccination. Current CDC website information notes that there are four pneumococcal vaccines available in the United States. Pneumococcal conjugate vaccines (PCVs: PCV15, PCV20 (Prevnar20), and PCV21) and pneumococcal polysaccharide vaccine (PPSV23). Each of these vaccines helps protect against specific serotypes, or strains, of pneumococcal bacteria. The number at the end of the vaccine name tells how many strains the vaccine includes. CDC Pneumococcal Vaccine Timing for Adults (https://www-new.cdc.gov/pneumococcal/downloads/Vaccine-Timing-Adults-JobAid.pdf) instructs that a complete series would be a PCV13 (Prevnar 13, pneumococcal conjugate vaccine) at any age, a PPSV23 (Pneumovax 23, pneumococcal polysaccharide vaccine) at greater than or equal to 65 years, and together with the resident, vaccine providers may choose to administer PCV20 (Prevnar 20, 20-valent pneumococcal conjugate vaccine) or PCV21 (CAPVAXIVE, 21-valent conjugate vaccine) to adults greater than or equal to [AGE] years old who have already received the PCV13 (but not PCV15, PCV20, or PCV21) at any age and PPSV23 at or after the age of [AGE] years old. The CDC stipulates that, Based on shared clinical decision-making, decide whether to administer one dose of PCV20 or PCV21 at least 5 years after the last pneumococcal vaccine dose. Current CDC information indicates that for someone greater than [AGE] years old, with no known prior pneumococcal vaccines, the first option is to administer the PCV20 or PCV21; and the second option is to administer the PCV15 followed by the PPSV23 after greater than one year. Clinical record review for Resident 30 revealed that the facility admitted him on March 28, 2025, when he was [AGE] years old. Review of Resident 30's immunization history revealed that he received the Prevnar13 before his admission to the facility on October 9, 2015, when he would have been [AGE] years old. Resident 30's clinical record contained no evidence that he received any additional pneumococcal vaccinations in the more than 10 years since his last immunization. Review of a Pneumococcal Immunization Consent/Declination dated October 20, 2025, revealed that Resident 30's daughter consented to Resident 30's pneumococcal vaccine. Per CDC guidelines, Resident 30 should have received either the PCV20 or PCV21 immunization. Clinical record review for Resident 54 revealed that the facility admitted her on August 22, 2024, when she was [AGE] years old. Review of a Pneumococcal Immunization Consent/Declination dated October 20, 2025, revealed that Resident 54 consented to pneumococcal immunization. Review of Resident 54's immunization history revealed no evidence that she received pneumococcal immunizations before her admission to the facility. Resident 54's immunization documentation indicated that the facility administered the PPSV23 immunization on October 30, 2025. Per CDC guidelines, the facility should have administered the PCV15, PCV20, or PCV21 immunization to Resident 54. Clinical record review for Resident 22 revealed that the facility admitted her on July 29, 2020, when she was [AGE] years old. Review of a Pneumococcal Immunization Consent/Declination dated October 20, 2025, revealed that Resident 22's daughter consented to pneumococcal immunization. Review of Resident 22's immunization documentation indicated that Resident 22 received the Prevnar13 vaccine on February 10, 2020, and the PPSV23 vaccine on (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	February 19, 2021. Resident 22's immunization documentation indicated that Resident 22 did not receive the PCV20 immunization because she was not eligible on February 5, 2025. Per CDC guidelines, Based on shared clinical decision-making, decide whether to administer one dose of PCV20 or PCV21 at least 5 years after the last pneumococcal vaccine dose. Based on Resident 22's immunization history and CDC guidelines, Resident 22 would have been eligible for a pneumococcal immunization in February 2026, however, there was no evidence that the facility offered Resident 22 pneumococcal revaccinations when she became eligible. Interview with the Director of Nursing on May 21, 2026, at 11:08 AM confirmed the above findings regarding pneumococcal immunizations for Residents 22, 30, and 54. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18(b)(1) Management 28 Pa. Code 211.12(d)(1)(5) Nursing services

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. Based on a review of select facility policies and procedures, clinical record review, and staff interview, it was determined that the facility failed to ensure residents were offered the COVID-19 immunization unless contraindicated for four of five residents reviewed for immunizations (Residents 5, 22, 30, and 54); and failed to maintain documentation related to staff COVID-19 vaccination status.Findings include: The facility policy entitled, Coronavirus Disease (COVID-19), Infection Prevention and Control Measures, last reviewed without changes on April 1, 2026, indicated that the facility follows infection prevention and control practices recommended by the Centers for Disease Control and Prevention to prevent the transmission of COVID-19 within the facility. The measures include encouraging staff, residents, and visitors to remain up to date with all COVID-19 vaccine doses, providing resources, and counseling about the importance of receiving the COVID-19 vaccine. Facility policies provided did not indicate that the facility would maintain documentation related to staff COVID-19 vaccination status. Interview with the Director of Nursing on May 20, 2026, at 3:27 PM and May 21, 2026, at 11:08 AM revealed that the facility had no evidence of facility documentation regarding staff COVID-19 immunization status. The interview indicated that, upon hire, staff are asked to provide an immunization card, or other documentation, regarding COVID-19 immunizations; however, the facility had no practice of offering or documenting staff COVID-19 immunizations after that time. Clinical record review for Resident 5 revealed that the facility admitted him on November 6, 2024. A COVID-19 Booster Consent or Refusal form signed on October 20, 2025, indicated that Resident 5's daughter gave verbal permission for him to receive the COVID-19 vaccine. Resident 5's clinical record did not contain evidence that he received a COVID-19 vaccine. Clinical record review for Resident 22 revealed that the facility admitted her on July 29, 2020. Review of Resident 22's immunization record revealed that the facility administered a COVID-19 vaccine on August 2, 2024. A COVID-19 Booster Consent or Refusal dated October 20, 2025, indicated that Resident 22's daughter gave verbal permission for her to receive the COVID-19 vaccine. Resident 22's clinical record did not contain evidence that she received a COVID-19 vaccine after August 2024. Clinical record review for Resident 30 revealed that the facility admitted him on March 28, 2025. A COVID-19 Booster Consent or Refusal form dated October 20, 2025, indicated that Resident 30's daughter gave verbal permission for him to receive the COVID-19 vaccine. Resident 30's clinical record did not contain evidence that he received a COVID-19 immunization. Clinical record review for Resident 54 revealed that the facility admitted her on August 22, 2024. A COVID-19 Booster Consent or Refusal form dated October 20, 2025, indicated that Resident 54 consented to receive the COVID-19 vaccine. Resident 54's clinical record did not contain evidence that she received a COVID-19 immunization. 28 Pa. Code 211.12(d)(1)(5) Nursing services

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation, clinical record review, and resident and staff interviews, it was determined that the facility failed to ensure that care and services were provided in a manner that enhanced resident dignity for two of three residents reviewed (Resident 8 and 25).Findings include: During an interview with Resident 8 on May 19, 2026, at 9:13 AM the resident stated she frequently prefers to keep her door closed and that staff often do not knock on her door before entering. During the interview, Employee 18, housekeeping, was observed entering Resident 8's room, opening the closed door without knocking and delivering laundry. After Employee 18 exited the room, Resident 8 indicated, See? They never knock. The facility failed to ensure residents' dignity related to valuing residents' private space. Clinical record review for resident 25 revealed a physician order dated November 11, 2025, for care of nephrostomy tubes (a thin catheter that drains urine from your kidney into an external bag). Observations on May 19, 2026, at 11:25 AM revealed Resident 25 sitting in a chair across from the nurse's station on Sage unit with a urinary catheter bag (a collection device connect to a catheter to hold urine) resting on their lap and appearing to be half full of yellow liquid. Observation on May 19, 2026, at 11:55 AM revealed staff standing Resident 25 up and clipping the urine bag to the outside of the resident's pants in order to assist the resident with ambulating the resident to the dining room. Observation on May 19, 2026, at 12:00 PM revealed Resident 25 sitting in the dining room with urine bags wrapped around the front arm support of their chair while the resident ate their lunch. The resident was then observed on May 19, 2026, at 12:23 PM ambulating down the hallway with two urine bags, one clipped to each side of their shirt, both filled with yellow liquid. The facility failed to ensure a resident's dignity related to leaving urinary catheter bags uncovered. The above concerns related to Resident 8 and Resident 25 were discussed with the Nursing Home Administrator and the Director of Nursing on May 19, 2026, at 3:00 PM. 28 Pa. Code 201.18(b)(1) Management

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	396137	A. Building B. Wing	05/21/2026

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. Based on clinical record review, review of select facility policies and procedures, and resident and staff interview, it was determined that the facility failed to determine a resident's capability to self-administer their medications for one of 18 residents reviewed (Resident 3).Findings include: The policy entitled Self-Administration of Medications, revealed residents have the right to self-administer medications if the interdisciplinary team has determined that it is clinically appropriate and safe for the residents to do so. As part of the evaluation comprehensive assessment, the interdisciplinary team (IDT) assesses each resident's cognitive and physical abilities to determine whether self-administering medication is safe and clinically appropriate for the resident. If it is deemed safe and appropriate for a resident to self-administer medications, it is documented in the medical record and the care plan. The decision that a resident can safely self-administer medications is re-assessed periodically based on changes in the resident's medical and /or decision-making status. Self-administered medications are stored in a safe and secure place, which is not accessible by other residents. If safe storage is not possible in the resident's room, the medications of residents permitted to self-administer are stored on a central medication cart, or in the medication room. Any medications found at the bedside that are not authorized for self-administration are turned over to the nurse in charge. Clinical record review revealed the facility admitted Resident 3 on September 3, 2025. Further review of Resident 3's clinical record revealed a physician order-initiated April 9, 2026, for staff to administer Voltaren Arthritis Pain External Gel (a topical ointment for pain relief), and to apply to Resident 3's right elbow, shoulder, and left hand topically two times a day for pain. Observation of Resident 3 on May 18, 2026, at 11:28 AM, revealed Resident 3 was at the nurses' station when Employee 10 (licensed practical nurse) handed Resident 3 a souffle cup with an unidentified white substance in it. Resident 3 proceeded to carry the souffle cup to his room. Observation and interview with Resident 3 on May 18, 2026, at 11:49 AM revealed the souffle cup with the white substance was on Resident 3's over bed table. Resident 3 stated that the substance in the souffle cup was his physician ordered Voltaren gel. He stated Employee 3 gave it to him for his shoulder pain. Resident 3 stated he would put it on his shoulder later. Further review of Resident 3's clinical record revealed no evidence of an assessment for Resident 3 to self-administer her medications. Interview with the Nursing Home Administrator and Director of Nursing on May 21, 2026, at 8:31 AM, confirmed the facility did not assess Resident 3's capability to self-administer his Voltaren gel. The Director of Nursing revealed that a Medication Self-Administration Screen was completed on May 20, 2026, after the surveyor's questioning and Resident 3 was deemed unable to safely administer his medications. The facility failed to determine Resident 3's capability to self-administer his medications. 28 Pa. Code 201.18(b)(1)(3)(e)(1) Management 28 Pa. Code 211.12(d)(1)(3)(5) Nursing Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	396137	A. Building B. Wing	05/21/2026

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F 0568 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Properly hold, secure, and manage each resident's personal money which is deposited with the nursing home. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and resident, family, and staff interviews it was determined that the facility failed to ensure the resident or resident's responsible party received a personal fund statement quarterly for two of two residents reviewed for personal funds concerns (Residents 6 and 22).Findings include: Interview with Resident 22's daughter on May 18, 2026, at 2:14 PM indicated that the facility holds money for her mother, however, she did not receive a quarterly statement. Resident 22's daughter confirmed that her mother lacks the cognitive capacity to manage her own financial affairs. Clinical record review for Resident 22 revealed profile information that listed her daughter as her financial and healthcare power-of-attorney (POA), substitute decision-maker, and resident representative. Quarterly MDS (Minimum Data Set, an assessment tool completed at specific intervals to determine resident care needs) assessments dated January 21, 2026, and March 24, 2026, assessed Resident 22 as rarely or never understood, with long- and short-term memory problems, and severely impaired cognitive skills for decision making. The handwritten notation on Resident 22's resident fund statement dated for the quarter January 1, 2026, through March 31, 2026, read, gets own did not send to POA. Interview with Employee 4 (business office manager) on May 20, 2026, at 10:59 AM confirmed that Resident 22's responsible party did not receive a resident fund statement; and that Resident 22 has cognitive deficits that prevent her comprehension of the financial record. Interview with Resident 6 on May 18, 2026, at 1:58 PM revealed that the facility business office staff hold money for her, however, she does not receive a statement at least quarterly. Resident 6 stated that she did not know who received the statement. On May 19, 2026, at 9:45 AM Resident 6 stopped the surveyor in the hallway to report again that she did not know who received her quarterly personal fund statement. Clinical record review for Resident 6 revealed that the facility admitted her on June 17, 2020. A quarterly MDS assessment dated [DATE], noted her BIMS (Brief Interview for Mental Status, short standardized cognitive screening tool that numerically scores question responses) score was 15 that indicated she had no cognitive impairments. Interview with Employee 4 on May 20, 2026, at 10:59 AM revealed that she prints quarterly statements and puts them in the activity box for Employee 3 (activities director) to deliver to residents. Interview with Employee 3 on May 20, 2026, at 11:01 AM indicated that she hand-delivers the statements that are in her box, however, she could not recall what residents get statements. She could not recall if she delivered a resident fund statement to Resident 6. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.29(a) Resident rights

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	396137	A. Building B. Wing	05/21/2026

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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. Based on observation and staff interview, it was determined that the facility failed to provide adequate housekeeping and maintenance services to ensure a clean, safe, and orderly environment on one of two nursing units (Ivy unit and Residents 8 and 39).Findings include: Observation of Resident 8's room on May 18, 2026, at 1:05 PM revealed strong urine-like odor, and a pile of linens in a soiled linen bag with some linens noted on top of the bag. Concurrent interview with the resident revealed that she is incontinent of bladder and frequently urinates on the floor, then cleans it independently and puts the soiled linens on the floor to be collected later. During resident interview, Employee 18, housekeeping, was observed entering the residents' room and stating, The floor is not as sticky today. Observation of Resident 8's room on May 19, 2026, at 11:38 AM revealed that the room continues to have a strong urine-like odor, and the floor remained sticky underfoot. Observation of Resident 39's bathroom on May 19, 2026, at 10:07 AM revealed that the floor was sticky underfoot. The counter behind the faucet was yellow and appeared stained. Concurrent interview with Resident 39 revealed that housekeeping cleans the bathrooms about once a week. Observation on May 20, 2026, at 10:45 AM of the wall across from the nursing station on Ivy unit revealed that the paint from the handrails along this wall was scrapped off, revealing bare metal. The above concerns were reviewed with the nursing home administrator and the director of nursing on May 20, 2026, at 12:30 PM. 483.10(i)(1)-(7) Safe/clean/comfortable/homelike EnvironmentPreviously cited deficiency 7/3/2025, and 10/30/25 28 Pa. Code 201.18(b)(3) Management

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	396137	A. Building B. Wing	05/21/2026

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on clinical record review and staff interview it was determined that the facility failed to ensure resident representative contact information was communicated to the receiving health care institution for one of four residents reviewed for hospitalization concerns (Resident 2).Findings include: Clinical record review for Resident 2 revealed nursing documentation dated April 22, 2026, at 6:40 PM that Resident 2 wanted to go to the emergency room due to pain in his back. Emergency services (911) were at the facility and transported Resident 2 via a stretcher. The writer indicated that Resident 2's sister was made aware of the transfer. Review of Resident 2's clinical record profile information revealed his sister was listed as his representative. An, eINTERACT Transfer Form (document generated by the facility's electronic medical record system to ensure appropriate information is communicated to a receiving health care institution or provider), dated April 22, 2026, completed for Resident 2's discharge to the hospital, revealed that Resident 2 was listed as his own resident representative; the facility did not include the contact information for his sister who was listed in his profile information as his representative. Interview with the Director of Nursing on May 20, 2026, at 10:46 AM confirmed that the eINTERACT Transfer Form is what is used by the facility to communicate information to the receiving hospital staff; and Resident 2's transfer form did not communicate Resident 2's representative contact information for his hospitalization as noted above. 483.15(c)(2)(iii)(3)-(6)(8)(d)(1)(2); 483.21(c)(2) Discharge ProcessPreviously cited deficiency 7/3/25 28 Pa. Code 201.14(a) Responsibility of license 28 Pa. Code 201.29(a) Resident rights

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	396137	A. Building B. Wing	05/21/2026

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. Based on clinical record review and staff interview it was determined that the facility failed to ensure that an assessment accurately reflected a resident's status for one of 18 residents reviewed (Resident 2).Findings include: Clinical record review for Resident 2 revealed nursing documentation dated April 22, 2026, at 3:08 PM that Resident 2 was on the floor. Resident 2 complained of mid back pain. Nursing documentation dated April 22, 2026, at 6:40 PM revealed that Resident 2 insisted on going to the emergency room due to back pain and 911 (emergency personnel) transported Resident 2 to the emergency room. Nursing documentation dated April 23, 2026, at 10:57 AM revealed that the writer called the hospital and obtained information that Resident 2 was admitted for vertebral (spinal) fractures for which he was going to have surgery. A Discharge MDS (Minimum Data Set, an assessment tool completed at specific intervals to determine resident care needs) dated April 22, 2026, assessed that Resident 2 had a fall with an injury that was not coded as a major injury. The facility staff signed the assessment section on April 24, 2026, at 5:02 PM. Review of the Long-Term Care Facility Resident Assessment Instrument User's Manual (RAI, MDS) instructions to complete Section J related to falls instructs that the definition for injury (except major) related to a fall includes, but is not limited to, skin tears, abrasions, lacerations, superficial bruises, hematomas, and sprains; or any fall-related injury that causes the resident to complain of pain. Major injury includes, but is not limited to, traumatic bone fractures, joint dislocations/subluxations, internal organ injuries, amputations, spinal cord injuries, head injuries, and crush injuries. Hospital Discharge Summary documentation for Resident 2's hospitalization from April 22, 2026, to April 27, 2026, noted that his principal diagnosis was fall with a T7-T8 (thoracic bones seven and eight) unstable fracture for which he underwent surgery. The surveyor confirmed the above MDS assessment injury coding error with the Nursing Home Administrator on May 20, 2026, at 11:38 AM. 28 Pa. Code 211.5(f)(ix) Medical records 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on clinical record review, observation, and staff interview it was determined that the facility failed to revise a resident's plan of care for one of 18 residents reviewed (Resident 30).Findings include: Clinical record review for Resident 30 revealed an active physician's order dated February 6, 2026, that Resident 30 was to wear tubigrips (specially designed elastic bandages used to reduce swelling) to his bilateral lower extremities every day. Observation of Resident 30 on May 19, 2026, at 10:22 AM revealed that his lower legs and ankles presented with swelling and he was not wearing tubigrips. Review of Resident 30's plans of care developed by the facility to address his care needs revealed no intervention that included the use of tubigrips daily to his bilateral lower extremities. Review of Resident 30's MAR/TAR (Medication Administration Record/Treatment Administration Record, electronic documentation completed by licensed nursing staff for the completion of care) dated May 2026 revealed that staff initialed the application of the tubigrips in the morning. The surveyor reviewed the above concerns regarding Resident 30's plan of care during an interview with the Nursing Home Administrator and the Director of Nursing on May 21, 2026, at 11:08 AM. 28 Pa. Code 211.5(f)(i)-(xi) Medical records 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	396137	A. Building B. Wing	05/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observation, clinical record review, and resident and staff interview, it was determined that the facility failed to provide a dependent resident with activities of daily living assistance for one of two residents reviewed (Resident 48).Findings include: Observation of Resident 48 on May 18, 2026, at 2:31 PM and May 19, 2026, at 12:34 PM revealed she was in bed and her hair appeared greasy. Interview with Resident 48 on May 19, 2026, at 12:34 PM revealed the resident was unable to recall when she last received a shower. Resident 48 stated she is supposed to receive a shower once a week. Clinical record review revealed the facility admitted Resident 48 on September 3, 2025. A review of Resident 22's most recent MDS (Minimum Data Set, an assessment completed at specific intervals to determine care needs) dated March 27, 2026, indicated nursing staff assessed Resident 48 as dependent on staff for bathing. Review of Resident 48's plan of care-initiated September 3, 2025, revealed Resident 48 has an activity of daily living self-care performance deficit and is totally dependent on staff to provide a bath or shower weekly and as necessary. A review of Resident 48's task documentation (ADL, activities of daily living charting) revealed her preference is to receive a shower every Thursday evening. Further review revealed Resident 48's documentation survey report (electronic documentation completed by nurse aide staff for the completion of ADL care) for March, April, and May 2026, indicated Resident 48 only received four showers/baths and refused twice. There was no documentation of staff offering, or Resident 48 refusing a shower/bath from May 1 to 21, 2026. The above findings for Resident 48 were reviewed with the Nursing Home Administrator and the Director of Nursing on May 20, 2026, at 12:39 PM. Further interview with the Director of Nursing on May 21, 2026, at 9:30 AM revealed she was unable to provide further documentation that the facility provided bathing assistance for Resident 48. 28 Pa Code 211.11(d)(1)(5) Nursing services

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	396137	A. Building B. Wing	05/21/2026

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on clinical record review and staff interview, it was determined that the facility failed to implement interventions to prevent falls for two of four residents reviewed for falls (Residents 8 and 37).Findings include: Clinical record review of Resident 37 revealed a fall without injuries occurring on February 13, 2026, in the resident's shower. The Interdisciplinary team determined that adding non-slip strips (tacky/rough material that adheres to surfaces) to the resident's shower would be an appropriate intervention, and that the care plan care plan (an outline of an individual's health needs, specific care requirements, and the actions necessary to achieve desired health outcomes, represented as the Focus, Goal, and Interventions) would be updated to reflect this. Observation of the resident's shower on May 20, 2026, at 9:30 AM revealed no non-slip strips were present. Interview with Employee 17, nurse aide, on May 20, 2026, at 934: AM, confirmed that the resident did not have any non-slip strips present in the shower in Resident 37's room, nor were any non-slip strips installed in the shower located on the unit. During an interview with the Nursing Home Administrator on May 20, 2026, at 9:45 AM, they were made aware of the above findings and confirmed that non-skid strips are strips that would be directly adhered to the floor. Review of Resident 8's care plan initiated on November 14, 2025, revealed a Focus area that the resident was at risk for falls, and an Intervention list that included Call don't Fall sign hung in the resident's room. Observation of Resident 8's room on May 20, 2026, at 9:20 AM, revealed no sign indicating Call don't Fall hanging anywhere in the room. During an interview with the resident at this time, they stated they do not recall there ever being a sign hung in their room that stated this. Interview with Employee 1, licensed practical nurse, on May 21, 2026, at 10:55 AM, confirmed that no sign was hanging in Resident 8's room related to falls or their call bell. The above information related to Resident 8 was reviewed with the Nursing Home Administrator on May 21, 2026, at 11:35 AM. 483.25 (d)(1)(2) Free of Accident Hazards/Supervision/DevicesPreviously cited 7/3/25 28 Pa. Code 211.12(d)(1)(5) Nursing services

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	396137	A. Building B. Wing	05/21/2026

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. Based on review of facility documentation and staff interview, it was determined that the facility failed to ensure that nursing staff possessed the appropriate competencies and skill sets related to the care and assessment of residents who utilize a lift, wound vac, PICC line, catheter care, medication administration, and dressing changes for two of four employees reviewed for competencies (Employees 5 and 6).Findings include: A review of the facility documentation revealed that the facility had a total of 70 residents receiving medications, 12 residents that utilize lifts (transfer equipment), one resident with a wound vac (medical device used to promote healing of complex wounds by applying controlled suction to the wound area) five residents with indwelling urinary catheters (insertion of a tube into the bladder to remove urine), 11 residents with dressing changes, one resident with IV therapy (intravenous therapy, a medical procedure that delivers fluids, medications, nutrients directly into a vein), and one resident with a PICC line (peripherally inserted central catheter inserted into a vein in the arm that reaches a large central vein near the heart to deliver medications, fluids, or nutrition). A request for nursing staff competencies for medication administration, lifts, wound vac, catheter care, dressing changes, IV therapy, and PICC line care revealed the facility was unable to provide any competencies for Employees 5 and 6 (registered nurses) in the last year. The findings were reviewed with the Nursing Home Administrator and Director of Nursing on May 20, 2026, at 12:47 PM. Further interview with the Director of Nursing on May 21, 2026, at 11:07 AM confirmed the facility could provide no documentation that ensured Employees 5 and 6 had specific competencies and skill sets to care for the residents' needs listed above. 28 Pa. Code 201.20 (a) Staff Development

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	396137	A. Building B. Wing	05/21/2026

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. Based on clinical record review and staff interview, it was determined that the facility failed to ensure that the resident's attending physician addressed and responded appropriately to pharmacy recommendations for two of five residents reviewed (Residents 3 and 10).Findings include: The policy entitled Consultant Pharmacist Reports, last reviewed without changes on April 1, 2026, revealed a record of the consultant pharmacist's observations and recommendation is made available in an easily retrievable form to nurses, physicians, and care planning team. Comments and recommendations concerning medication therapy are communicated in a timely fashion. The timing of these recommendations should enable a response prior to the next medication regimen review. Recommendations are acted upon and documented by the facility staff and/or physician. If the physician does not respond to recommendations directed to him/her within 45 days, the Director of Nursing and/or the consultant pharmacist may contact the medical director. Clinical record review for Resident 3 revealed a consultant pharmacy review dated January 31, 2026, requesting Resident 3's physician add mix into 4 to 8 ounces of fluid to his Polyethylene Glycol order. Resident 3's physician did not address this pharmacy recommendation until April 5, 2026. Interview with the Director of Nursing on May 21, 2026, at 10:38 AM confirmed the above findings for Resident 3. Clinical record review for Resident 10 revealed a consultant pharmacy recommendation dated August 30, 2025, requesting an appropriate diagnosis for her prescribed Klonopin (medication used to treat her mood disorder). Further review of Resident 10's clinical record revealed no evidence that the facility staff and/or Resident 10's physician addressed the August 30, 2025, recommendation. A consultant pharmacy recommendation dated December 31, 2025, noted Resident 10 is receiving Atorvastatin (medication used to treat cholesterol levels), Magnesium, and Depakote (an anticonvulsant medication used to treat seizure and bipolar disorders) and requested Resident 10's physician ensure that labs are conducted to monitor these medications and the results should be accessible for review. Further review of Resident 10's clinical record revealed no evidence that the facility staff and/or Resident 10's physician addressed the December 31, 2025, recommendation, or obtained the requested labs. Further review of Resident 10's clinical record revealed the facility was unable to provide documentation that the pharmacy completed a monthly review for March 2026. Interview with the Director of Nursing on May 21, 2026, at 10:46 AM confirmed the above findings for Resident 10. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services

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	396137	A. Building B. Wing	05/21/2026

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, observation, and resident, staff, and family interview, it was determined that the facility failed to provide routine dental services for two of four residents reviewed for dental concerns (Residents 22 and 3). Findings include: Interview with Resident 22's daughter on May 18, 2026, at 2:17 PM revealed that she believed Resident 22 had, bad natural teeth; I think they are beyond (repair) at this point. Resident 22's daughter stated that she was not opposed to her mother receiving services from the facility's contracted dental provider. Clinical record review for Resident 22 revealed an annual MDS (Minimum Data Set, an assessment tool completed at specific intervals to determine resident care needs) assessment dated [DATE], that assessed Resident 22 as having obvious or likely cavity or broken natural teeth. The CAA (Care Assessment Area) for dental concerns triggered to prompt the facility to develop a plan of care regarding dental needs. Review of a plan of care initiated by the facility on November 13, 2023, to address Resident 22's risk for altered dentition and/or mucus membranes related to missing teeth and broken teeth revealed interventions that included obtaining dental consultation as necessary. Resident 22's clinical record revealed documentation by the facility's consultant dentist dated April 10, 2025 (more than a year earlier than the onsite survey) and documentation by the facility's consultant dental hygienist dated February 9, 2026. Interview with the Director of Nursing and the Nursing Home Administrator on May 21, 2026, at 8:15 AM revealed that the facility had no further evidence of professional dental services provided twice a year as covered under the State plan for Resident 22. Observation and interview with Resident 3 on May 18, 2026, at 11:31 AM revealed Resident 3 appeared edentulous (no natural teeth). Interview with Resident 3 at this time revealed he has not been offered to see a dentist since admission. He stated he had dentures at home, but they did not fit correctly. Clinical record review revealed the facility admitted Resident 3 on September 3, 2025, with payment sources that included the state Medicaid benefit starting September 15, 2026. Review of Resident 3's admission MDS dated [DATE], revealed staff assessed Resident 3 as having no obvious or likely cavity or broken natural teeth. Review of Resident 3's plan of care-initiated September 9, 2025, revealed Resident 3 is at risk for altered dentition and/or mucous membranes related to his edentulous status, noting Resident 3 does not wear dentures. Interventions included obtaining a dental consultation for Resident 3 as necessary. The facility was unable to provide any documentation that they offered Resident 3 dental services. Interview with the Nursing Home Administrator on May 21, 2026, at 8:03 AM confirmed the above findings for Resident 3. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services 28 Pa. Code 211.15. Dental services

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	396137	A. Building B. Wing	05/21/2026

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on closed clinical record review and staff interview, it was determined that the facility failed to ensure an accurately documented clinical record for one of 21 residents reviewed (Resident 77).Findings include: Closed clinical record review for Resident 77 revealed that the facility discharged her on April 14, 2026. Nursing documentation dated April 14, 2026, at 10:06 PM revealed that Resident 77 was without response to verbal stimuli, without respirations. and without heart sounds. The nurse documented Resident 77's time of death as 9:30 PM. Nursing documentation dated April 14, 2026, at 11:32 PM revealed that the funeral home removed Resident 77's body from the facility. Physician discharge documentation dated April 14, 2026, at 11:54 PM noted, Care Plan: Comments: Encourage low salt diet and moderation with fluids. Otherwise fairly stable fluid status at this time. The surveyor reviewed the above concerns regarding inaccurate clinical documentation for Resident 77 during an interview with the Nursing Home Administrator and the Director of Nursing on May 20, 2026, at 8:29 AM. 28 Pa. Code 211.5(f)(i)-(xi) Medical records 28 Pa. Code 211.12(d)(3) Nursing services

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly Based on a review of Quality Assurance and Performance Improvement (QAPI) meeting attendance and staff interview it was determined that the facility failed to ensure the committee met at least quarterly and consisted of the minimum members (Infection Preventionist).Findings include: Review of facility documentation of QAPI committee meeting attendance dated August 26, 2025, to April 30, 2026, revealed that the facility failed to conduct a meeting for the first quarter of 2026 (January, February, or March). Attendance records indicated that the facility conducted a meeting on December 30, 2025, and again on April 30, 2026. Review of the attendance records dated April 30, 2026, revealed that the infection preventionist did not attend the meeting. Interview with the Nursing Home Administrator on May 21, 2026, at 11:03 AM confirmed the above findings. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18(b)(3)(e)(3) Management

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	396137	A. Building B. Wing	05/21/2026

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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, review of posted daily nurse staffing data, and staff interview, it was determined that the facility failed to post and retain posted nursing staffing information for the past 18 months for two of two nursing stations (Ivy and Sage). Findings include: Observation of the facility on May 18, 2026, at 2:12 PM and May 19, 2026, at 5:09 PM revealed no evidence nursing staffing hours for the day were posted in the facility. A review of documentation provided by the facility that contained daily nurse staffing postings for April and May 2026, revealed that the facility did not have postings for the following dates and/or shifts: April 3, 2026 (second shift)April 5, 2026 (third shift)April 6, 2026April 7, 2026 (third shift)April 8, 2026April 9, 2026April 10, 2026April 11, 2026April 12, 2026April 14, 2026April 15, 2026 (second shift)April 16, 2026 (second shift)April 17, 2026 (second shift)April 18, 2026April 19, 2026April 20, 2026April 21, 2026 (second and third shifts)April 22, 2026 (second shift)April 23, 2026 (second and third shifts)April 24, 2026April 25, 2026April 26, 2026April 27, 2026 (second and third shifts)April 28, 2026April 29, 2026 (second shift)April 30, 2026 (second shift)May 1, 2026 (second shift)May 2, 2026May 3, 2026May 4, 2026May 5, 2026 (second and third shifts)May 6, 2026 (second and third shifts)May 7, 2026 (first and second shifts)May 8, 2026 (first and second shifts)May 9, 2026 (second and third shifts)May 10, 2026May 11, 2026May 12, 2026 (third shift)May 13, 2026 (second shift)May 14, 2026 (second shift)May 15, 2026 (second shift)May 16, 2026 (second and third shifts)May 17, 2026May 18, 2026May 19, 2026May 20, 2026 (second shift) Interview with the Director of Nursing on May 21, 2026, at 11:03 AM confirmed these findings. 28 Pa. Code 201.14(a) Responsibility of licensee