

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395101	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 03/07/2025
NAME OF PROVIDER OR SUPPLIER: SAYRE HEALTH CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: 151 KEEFER LANE SAYRE, PA 18840		
STATE LICENSE NUMBER: 192102				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0000	INITIAL COMMENT	F 0000		
F 0578	Based on a Medicare/Medicaid Recertification Survey, State Licensure Survey, Civil Rights Compliance Survey, and an Abbreviated Survey to investigate a Complaint, completed on March 7, 2025, it was determined that Sayre Health Care Center was not in compliance with the following requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care and the 28 PA Code, Commonwealth of Pennsylvania Long Term Care Licensure Regulations.	F 0578		
SS=D				

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE:

(X6) DATE:

Any deficiency statement ending with an asterisk (*) denotes a deficiency which may be excused from correction providing it is determined that other safeguards provide sufficient protection to the patients. The findings stated above are disclosable whether or not a plan of correction is provided. The findings are disclosable within 14 days after such information is made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

This form is a printed electronic version of the CMS 2567L. It contains all the information found on the standard document in much the same form. This electronic form once printed and signed by the facility administrator and appropriately posted will satisfy the CMS requirement to post survey information found on the CMS 2567L.

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F 0578 SS=D	Continued from page 1 483.10(c)(6)(8)(g)(12)(i)-(v) Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance	F 0578	1. All residents were unharmed, including Resident 175. Resident 175 Advanced Directive was reconciled and corrected immediately. 2. The Facility Administrator and the Interdisciplinary Team promptly assessed all existing residents to verify that their advanced directive and code status were accurate, up-to-date, and readily available to staff in the event of an occurrence. 3. All staff members received training on how to find the code status in the event of an occurrence. Additionally, all nurses were instructed and educated on the significance of updating residents upon their return from the hospital to ensure that the advance directives are accurate and up-to-date in case of an incident. 4. The Director of Nursing or designee will conduct weekly audits for a duration of four weeks, followed by monthly audits for three months. Physician Orders, Care Plan and spine of hard chart will be reviewed to verify accuracy and currency of each residents advance	Completion Date: 03/24/2025 Status: APPROVED Date: 03/18/2025

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F 0578 SS=D	Continued from page 2 directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by:	F 0578	directive The findings will be presented at the monthly Quality Assurance meeting for review.	

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F 0578 SS=D	Continued from page 3 Based on clinical record review and staff interview, it was determined that the facility failed to honor advance directive choices for one of 24 residents reviewed (Resident 175). Findings include: Clinical record review for Resident 175 revealed that on August 1, 2024, the resident's responsible party indicated that the resident was a full code (staff was to start CPR [Cardiopulmonary Resuscitation]). On February 27, 2025, Resident 175's responsible party completed a POLST (Physician Orders for Life-Sustaining Treatment, a form directing medical staff to complete life-sustaining treatment or allow a natural death) form and a facility code status form (a form directing life-sustaining care) both which indicated Do Not Resuscitate (DNR) for Resident 175. Resident 175's code status form was also signed by the physician on February 27, 2025. There was no documentation that the facility	F 0578		

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F 0578 SS=D	Continued from page 4 changed Resident 175's code status order from full code to DNR until March 6, 2025. The above information was reviewed during an interview on March 6, 2025, at 3:39 PM with the Nursing Home Administrator. 28 Pa. Code 201.29(c) Resident rights 28 Pa. Code 211.10(a) Resident care policies 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services	F 0578		
F 0582 SS=D		F 0582		

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F 0582 SS=D	<p>Continued from page 5</p> <p>483.10(g)(17)(18)(i)-(v) Medicaid/Medicare Coverage/Liability Notice</p> <p>§483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section.</p> <p>§483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation</p>	F 0582	<ol style="list-style-type: none"> 1. No residents were harmed. Resident 2 expired so the facility was unable to provide the notice to the resident. 2. The social services department evaluated the accuracy of residents requiring a CMS-10055 form to verify that they had been notified timely regarding the termination of their Medicare coverage. 3. The facility administrator educated the social services department about the necessity of promptly notifying residents when their Medicare coverage has concluded, emphasizing that the resident must sign a CMS-10055 form as part of this notification process. 4. The facility administrator or designee will conduct weekly audits for a duration of four weeks, followed by monthly audits for three months. This process aims to confirm that residents are informed about the Medicare cut-off date and are signing the CMS-10055 form. The results of these audits will be presented at the monthly Quality 	<p>Completion Date: 03/24/2025 Status: APPROVED Date: 03/18/2025</p>

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F 0582 SS=D	Continued from page 6 of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by:	F 0582	Assurance meeting for evaluation.	

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F 0582 SS=D	Continued from page 7 Based on clinical record review and staff interview, it was determined that the facility failed to provide the required notification to a resident whose payment coverage changed for one of three residents reviewed (Resident 2). Findings include: A review of the form "Instructions for the Notice of Medicare Non-Coverage (NOMNC) CMS-10123," (a notice that informs the recipient when care received from the skilled nursing facility is ending; and how to contact a Quality Improvement Organization (QIO) to appeal) revealed instructions that a Medicare provider must ensure that the notice is delivered at least two calendar days before Medicare covered services end. A review of the "Form Instructions Skilled Nursing Facility (SNF) Advanced Beneficiary Notice of Non-coverage (SNFABN) Form CMS-10055" revealed that examples of the common reasons why an extended care stay, or services may not be	F 0582		

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F 0582 SS=D	Continued from page 8 covered under Medicare might include the beneficiary no longer requires daily skilled care for a medical condition but wants to continue residing in the skilled nursing facility (SNF). The SNF enters a good faith estimate of the cost of the corresponding care that may not be covered by Medicare. In the blank that follows "Beginning on ...," the skilled nursing facility enters the date on which the beneficiary may be responsible for paying for care that Medicare is not expected to cover. The beneficiary selects an option box to indicate a desire to continue to receive the care or not to continue to receive the care and if there is a desire to have the bill submitted to Medicare for consideration. The beneficiary or their authorized representative must sign the signature box to acknowledge that they read and understood the notice. The SNF must issue this notice when there is a termination of all Medicare Part A services for coverage reasons. If after issuing the NOMNC, the SNF expects the beneficiary to remain in the facility in a non-covered stay, the SNFABN must be issued to inform the beneficiary of potential liability for the non-covered	F 0582		

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F 0582 SS=D	Continued from page 9 stay. Clinical record review for Resident 2 revealed census information that Medicare payment for care ended July 26, 2024. Resident 2 remained in the facility. Review of a CMS-10123 form for Resident 2 confirmed that the last covered day of Medicare payment was July 26, 2024. There was no evidence that the facility provided a CMS-10055 form to Resident 2. Interview with the Nursing Home Administrator on March 7, 2025, at 12:00 PM confirmed that there was no additional evidence that Resident 2 received the CMS-10055 form after Medicare payment for her care stopped, but she remained in the facility. 483.10(g)(17)(18)(i)-(v) Medicaid/medicare Coverage/liability Notice Previously cited deficiency 4/19/24	F 0582		

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F 0582 SS=D	Continued from page 10 28 Pa. Code 201.18(b)(2)(e)(1) Management 28 Pa. Code 201.29(a) Resident rights	F 0582		
F 0584 SS=D		F 0584		

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F 0584 SS=D	<p>Continued from page 11</p> <p>483.10(i)(1)-(7) Safe/Clean/Comfortable/Homelike Environment</p> <p>§483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.</p> <p>§483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;</p> <p>§483.10(i)(3) Clean bed and bath linens that are in good condition;</p> <p>§483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);</p> <p>§483.10(i)(5) Adequate and comfortable lighting levels in all</p>	F 0584	<p>1. No residents were harmed. Resident 24's room under window was repaired and painted. The noted cigarette butts by the egress leading to the laundry facility was immediately cleaned up by the housekeeping staff. Resident 50's bathroom wall was patched and painted. Resident 54's bathroom was patched and painted. The furniture in the Unit 2 lounge were immediately disposed of and replenished with a love seat and chairs collected throughout the facility. The Unit 2 dining room was also patched and painted.</p> <p>2. The Facility Administrator, Maintenance Supervisor, and Housekeeping Supervisor conducted a visual inspection of the facility and its grounds to pinpoint any areas requiring repair or furniture that might need to be replaced.</p> <p>3. The Facility Administrator educated the Maintenance and Housekeeping departments to maintain a consistently safe, comfortable, and clean environment</p>	<p>Completion Date: 03/24/2025 Status: APPROVED Date: 03/18/2025</p>

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F 0584 SS=D	Continued from page 12 areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by:	F 0584	for the residents at all times. Maintenance and the Housekeeping Supervisor will complete weekly rounds of the facility and present any noted issues or repairs in morning meeting. 4. The Facility Administrator and or designee will conduct random audits on a weekly basis for a duration of four weeks, followed by monthly audits for three months. This process aims to ensure that all residents are provided with a clean and comfortable environment. All completed audits will be presented at the monthly Quality Assurance meeting for evaluation.	

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F 0584 SS=D	Continued from page 13 Based on observation and staff interview, it was determined that the facility failed to provide a clean, comfortable, and homelike environment on one of two nursing units reviewed (Nursing Unit 2; Residents 24, 50, and 54). Findings include: Observation of Resident 24's room on March 4, 2025, at 12:54 PM; and March 7, 2025, at 12:45 PM revealed a six-foot section of wall located under the resident's window that had a large, black colored linear stain and marring in various areas. Observation with the Nursing Home Administrator (NHA) of an egress area leading outside to the laundry building on March 6, 2025, at 11:17 AM revealed multiple partially smoked cigarette butts discarded on the ground. A concurrent interview with the NHA revealed it was unclear who the cigarette butts belonged to since the facility is non-smoking.	F 0584		

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F 0584 SS=D	Continued from page 14 The above information for Resident 24's room and the egress area was reviewed in a meeting with the Nursing Home Administrator on March 7, 2025, at 12:38 PM. Observation of the Unit 2 Nursing Unit on the following dates and times revealed: On March 4, 2025, at 11:53 AM the drywall was marred on the lower corner of the wall to the left of Resident 50's bathroom. On March 4, 2025, at 12:30 PM the drywall was warred and gouged on the lower corner of the wall to the left of Resident 54's bathroom. On March 5, 2025, at 9:05 AM there were two fake leather love seats in the lounge near Unit 2 entrance. Both love seat's fake leather was significantly peeling on the seat cushions and arm rests with cloth showing underneath. On March 5, 2025, at 9:25 AM the drywall of Unit	F 0584		

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F 0584 SS=D	Continued from page 15 2's dining room walls near the hallway and the door to the courtyard were gouged at both foot and table height. The above information was reviewed during an interview with the Nursing Home Administrator on March 5, 2025, at 2:15 PM. 28 Pa. Code 201.18(b)(3)(e)(2.1) Management	F 0584		
F 0607 SS=D		F 0607		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395101	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 03/07/2025
NAME OF PROVIDER OR SUPPLIER: SAYRE HEALTH CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: 151 KEEFER LANE SAYRE, PA 18840		
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F 0607 SS=D	Continued from page 16 483.12(b)(1)-(5)(ii)(iii) Develop/Implement Abuse/Neglect Policies §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, §483.12(b)(4) Establish coordination with the QAPI program required under §483.75. §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements. §483.12(b)(5)(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act. §483.12(b)(5)(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act.	F 0607	1. No residents were harmed. Employee 7, who served as a dietary cook, was promptly removed from the schedule and will not be permitted to return until fingerprints are collected for the personnel record. 2. The human resources department conducted an audit of employee files to verify that all "out of state" employees had successfully undergone FBI fingerprint background checks. 3. The facility administrator educated the HR department of the essential requirements to ensure that "out of state" employees are completing the required fingerprint background checks. The HR Director will complete a new hire checklist sheet to ensure all FBI/fingerprint background checks are completed within 90 days of hire. 4. The Facility Administrator or designee will conduct weekly audits for a duration of four weeks, followed by monthly audits for an additional three months, to verify that fingerprint background checks	Completion Date: 03/24/2025 Status: APPROVED Date: 03/18/2025

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F 0607 SS=D	Continued from page 17 This REQUIREMENT is not met as evidenced by:	F 0607	are being performed on "out of state" new hires in a timely manner. All audit findings will be presented at the monthly Quality Assurance meeting for evaluation.		

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F 0607 SS=D	Continued from page 18 Based on review of the facility policy, employee personnel records, and staff interview, it was determined that the facility failed to develop and implement an abuse prohibition policy that required a thorough investigation of prospective employee's employment history for one of five newly hired employees reviewed (Employee 7). Findings include: The policy entitled "Abuse Policy and Procedure" last reviewed without changes on June 13, 2024, revealed that the facility will protect the residents from abuse, neglect, misappropriation of resident property, corporal punishment and involuntary seclusion. The facility will not apply and employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law. All potential employees are screened for a history of abuse, neglect, and misappropriation of property by completing a state criminal background on all prospective employees and if not a resident of the state (where the facility was located) for two	F 0607		

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F 0607 SS=D	Continued from page 19 consecutive years, an FBI (Federal Bureau of Investigation) check will be conducted. Review of Employee 7's, cook, personnel record on March 7, 2025, revealed that the facility hired them on October 29, 2024, (129 days prior). Employee 7's personnel record revealed that she did not live in the same state as the facility location for more than two years. Further review of Employee 7's record did not reveal any evidence that the facility attempted to obtain or complete an FBI background check to determine criminal history for Employee 7. Interview with Employee 8, human resources, on March 7, 2025, at 10:45 AM and the Nursing Home Administrator on March 7, 2025, at 11:05 AM, revealed that the facility failed to complete the FBI background check within 90 days of employment and confirmed that Employee 7 provided services and access to residents since employed. 28 Pa. Code 201.18(b)(1)(3) Management	F 0607		

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F 0607 SS=D	Continued from page 20 28 Pa. Code 201.19 Personnel policies and procedures 28 Pa. Code 201.29(a) Resident rights 28 Pa. Code 211.12(d)(1)(5) Nursing services	F 0607		
F 0656 SS=D		F 0656		

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F 0656 SS=D	Continued from page 21 483.21(b)(1)(3) Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv) In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future	F 0656	1. No residents were harmed. Employee 3 and 6 were educated to reapproach residents when they show signs of agitation. Resident 44 care plan was updated to reflect her plan of care. Resident 5 care plan was updated and reviewed to reflect the plan of care. 2. The Director of Nursing reviewed residents care plans to ensure they reflect their current plan of care. 3. The Director of Nursing provided education to the RNAC and nursing staff regarding the significance of revising care plans to align with the individualized needs of the residents. All updated care plans or resident information will be found on PCC in the Kardex section of the EMR. 4. The Director of Nursing or designee will perform care plan audits weekly for a period of four weeks, subsequently transitioning to monthly audits for three months. The results will be reported at the monthly Quality Assurance meeting for assessment.	Completion Date: 03/24/2025 Status: APPROVED Date: 03/18/2025

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F 0656 SS=D	Continued from page 22 discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by:	F 0656		

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F 0656 SS=D	Continued from page 23 Based on clinical record review and staff and resident interview, it was determined that the facility failed to develop and implement a comprehensive care plan for two of 18 residents reviewed (Residents 44 and 5). Findings include: Interview with Resident 44 on March 4, 2025, at 11:56 AM revealed that two staff provided her assistance to complete her most recent shower ,and they were, "slam bam," with the shower care. Resident 44 denied that staff were abusive, but she confirmed that she did not appreciate the approach staff used when providing her care. Review of electronic Task Documentation (electronic system for nurse aides to document the provision of care) dated February 2025, revealed that Employee 3 (nurse aide) documented Resident 44 received a shower on Friday evening, February 28, 2025.	F 0656		

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F 0656 SS=D	Continued from page 24 Interview with Employee 3 on March 5, 2025, at 2:25 PM revealed that she remembered Resident 44's shower experience on February 28, 2025. Employee 3 stated that another nurse aide, Employee 6, asked her to witness Resident 44's shower care because Resident 44 was known to make false accusations against staff. Employee 3 stated that she witnessed Employee 6 begin to propel Resident 44 into the shower room via her wheelchair when Resident 44 began to get agitated stating that Employee 6 was hurting her shoulder (although Employee 6 had made no physical contact with Resident 44's body, only the handles of her wheelchair). Then Resident 44 began yelling at Employees 3 and 6 that they were going to damage her hearing aids in the shower although the hearing aids were in the charger in her room. Clinical record review for Resident 44 revealed a plan of care initiated on December 7, 2024, that Resident 44 had a right to refuse care. Interventions included instructions, "If resident becomes agitated or combative remove yourself (sic) from resident	F 0656		

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F 0656 SS=D	Continued from page 25 and reattempt when at a later time when calmer," and "Staff will re-approach resident at a later time." A plan of care initiated by the facility on December 16, 2024, due to Resident 44's trigger for cognitive loss due to noted behaviors listed interventions that included, "Provide the resident with necessary cues, stop, and reapproach if agitated." The facility did not develop a care plan for Resident 44 that included an intervention that two staff should provide care due to her known behavior of false accusations. Staff failed to implement the interventions to stop care and reapproach Resident 44 when she exhibited agitated behaviors with false accusations. The surveyor reviewed the above concerns regarding Resident 44 during an interview with the Nursing Home Administrator and Employee 5 (director of rehab) on March 5, 2025, at 2:00 PM. Interview with Resident 5 on March 4, 2025, at	F 0656		

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F 0656 SS=D	Continued from page 26 11:42 AM revealed the resident has an implanted pacemaker (a device implanted into the chest used to control the heartbeat). The resident also has a pacemaker transmitter device on the windowsill that is utilized to remotely monitor and transmit information from the resident's pacemaker. The resident further noted the device has an alarm that activates if there is an issue with the pacemaker or "a tower is not close enough." Per the resident, the device has not alarmed since being at the facility. Medical provider documentation for Resident 5 dated March 1, 2025, at 7:52 PM noted the resident has a cardiac pacemaker. Interview with Employee 9, license practical nurse, on March 6, 2025, at 11:33 AM revealed that staff are to call the number located on the device if it would alarm. Employee 9 further noted that any additional information related to the device "should be on the chart." Further review of the clinical record (both the	F 0656		

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F 0656 SS=D	Continued from page 27 electronic health record and the paper chart) for Resident 5 revealed no information related to the pacemaker monitoring/transmitting device. The facility provided a "Quick Start Guide" for the transmitter after questioning by the surveyor that included information such as: the transmitter should be no more than 10 feet from the bed, information on transmitting data such as the resident being within one foot of the device, not using a phone during transmission, positioning of the transmitter during sleep, and troubleshooting information. There was no care plan for Resident 5 that addressed care or precautions related to the pacemaker or the associated transmitting device. The facility later provided a care plan for Resident 5 that was dated as created and initiated on March 7, 2025, after discussion with the surveyor. Clinical record review for Resident 5 revealed the resident was currently on Eliquis (a medication that	F 0656		

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F 0656 SS=D	<p>Continued from page 28</p> <p>helps to prevent blood clots and stroke) 5 milligrams (mg) two times a day by mouth.</p> <p>Clinical record review for Resident 5 revealed no care plan related to the medication or evidence that the facility was monitoring the resident for side effects (such as bleeding) associated with the Eliquis.</p> <p>Further review of the clinical record for Resident 5 revealed an order dated March 7, 2025, at 10:26 AM, after discussion with the surveyor, to instruct staff to monitor for signs and symptoms of bleeding due to being on anticoagulant medication (a medication to help prevent blood clots). The facility also created a care plan related to anticoagulation therapy for Resident 5 that was initiated on March 7, 2025, after surveyor questioning.</p> <p>The above information for Resident 5 was reviewed with the Nursing Home Administrator on March 7, 2025, at 10:49 AM.</p> <p>28 Pa. Code 211.12(d)(1)(5) Nursing services</p>	F 0656		

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F 0661 SS=D	483.21(c)(2)(i)-(iv) Discharge Summary §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services. This REQUIREMENT is not met as evidenced by:	F 0661	1. Resident CR1 was not harmed. 2. The Director of Nursing reviewed discharged residents for the last two months to ensure necessary components were documented on the discharge summaries. 3. The Director of Nursing educated the RN supervisors of the importance of including all essential elements on the discharge summary, specifically emphasizing the need to document any wound care treatments provided during their care at the facility. 4. The Director of Nursing will audit discharge summaries weekly for four weeks, then monthly for three months to ensure essential elements, specifically any wound treatments are indicated on the discharge summary.	Completion Date: 03/24/2025 Status: APPROVED Date: 03/18/2025

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F 0661 SS=D	Continued from page 30 Based on closed clinical record review and staff interview, it was determined that the facility failed to provide a discharge summary with the necessary components for one of three closed records reviewed (Resident CR1). Findings include: Closed clinical record review for Resident CR1 revealed nursing documentation dated January 6, 2025, at 4:28 PM that Resident CR1 was discharged to home with home health services. Further review of the closed clinical record for Resident CR1 revealed wound care documentation dated January 3, 2025, that noted the resident had a Stage 3 Pressure Ulcer (full-thickness loss of skin, in which subcutaneous fat may be visible in the ulcer and granulation tissue) to the sacrum (a bone at the base of the spinal column). Closed record review for Resident CR1 revealed a document titled, "Resident Discharge Summary,"	F 0661		

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F 0661 SS=D	Continued from page 31 dated January 6, 2025. The document was signed by the resident's responsible party and the discharging nurse. The discharge summary did not include anything about the resident's wound, consultation, or recommended treatment by wound care. The section titled "Wound Care/Treatment" was documented as, "None." The facility failed to provide a discharge summary for Resident CR1 that contained a full recapitulation of the resident's stay that included, but is not limited to, diagnoses, course of illness, treatment, therapy, and pertinent lab, radiology, and consultation results. The above information for Resident CR1 was reviewed in a meeting with the Nursing Home Administrator on March 7, 2025, at 1:35 PM. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services	F 0661		
F 0676 SS=D		F 0676		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395101	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 03/07/2025
NAME OF PROVIDER OR SUPPLIER: SAYRE HEALTH CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: 151 KEEFER LANE SAYRE, PA 18840		
STATE LICENSE NUMBER: 192102				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0676 SS=D	Continued from page 32 483.24(a)(1)(b)(1)-(5)(i)-(iii) Activities Daily Living (ADLs)/Mntn Abilities §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that: §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ... §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living: §483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care, §483.24(b)(2) Mobility-transfer and ambulation, including walking, §483.24(b)(3) Elimination-toileting,	F 0676	1. Resident 5 and 44 were unharmed. Resident 5 is currently completing an RNP program. Resident 44 is currently completing an RNP program. 2. The Therapy Director completed an audit on any residents discharged from therapy services to indicate if they needed or had an RNP program in place. 3. The Therapy Director conducted an education with the therapy staff to ensure that the RNP is implemented upon the patient's discharge from therapy services, if necessary. 4. The Therapy Director or designee will conduct weekly audits for a duration of four weeks, followed by monthly audits for three months, to verify the implementation of the RNP for the resident, if required. The Therapy Director will bring the audit to the monthly QA meeting for review.	Completion Date: 03/24/2025 Status: APPROVED Date: 03/18/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395101	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 03/07/2025
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F 0676 SS=D	Continued from page 33 §483.24(b)(4) Dining-eating, including meals and snacks, §483.24(b)(5) Communication, including (i) Speech, (ii) Language, (iii) Other functional communication systems. This REQUIREMENT is not met as evidenced by:	F 0676		

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F 0676 SS=D	Continued from page 34 Based on clinical record review and resident and staff interview, it was determined that the facility failed to provide care and services to maintain or improve the ability to perform activities of daily living for two of five residents reviewed for rehabilitation concerns (Residents 5 and 44). Findings include: An interview with Resident 5 on March 4, 2025, at 11:18 AM revealed that she has been doing her own exercises and is currently not in therapy. A review of the task documentation (located in the electronic health record where staff document specific care related events for a resident) for Resident 5 revealed a restorative nursing program (RNP) dated March 3, 2025, that noted the following: RNP Sit to Stands: with use of grab bars resident to come to a standing position, hold for a count of 10, and sit for 10. Nursing documentation for Resident 5 dated March	F 0676		

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F 0676 SS=D	Continued from page 35 3, 2025, at 9:37 AM revealed the resident is starting on a new RNP program. An occupational therapy discharge summary for Resident 5 dated February 4, 2025, noted dates of service as October 22, 2024, to January 27, 2025. Discharge recommendations for functional maintenance included sit-to-stands at grab bars, assist x1, standing as tolerated. A physical therapy discharge summary for Resident 5 dated February 24, 2025, noted dates of service as October 22, 2024, to January 27, 2025. Discharge recommendations noted a restorative transfer program that included sit-to-stands at grab bars. Further review of the task documentation for Resident 5 revealed that staff had not documented any RNP exercises until March 3, 2025, despite a discharge date from therapy noted as January 27, 2025.	F 0676		

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F 0676 SS=D	Continued from page 36 An interview with Employee 5, Director of Therapy, on March 7, 2025, at 10:55 AM, with the Nursing Home Administrator present, confirmed that Resident 5 was discharged from therapy on January 27, 2025, and did not start the recommended restorative program until March 3, 2025, due to the program being "missed." Interview with Resident 44 on March 4, 2025, at 12:01 PM revealed that she believed that she was advanced from routine skilled therapy services. Due to cognitive deficits, Resident 44 had difficulty expressing if nursing or skilled therapy (physical therapy or occupational therapy) staff performed exercises with her, just that she had, "move up day (interpreted to mean discharged from skilled therapy to restorative nursing services)." A physical therapy discharge summary dated February 26, 2025, indicated that Resident 44 reached her maximum potential ,and Resident 44 would remain in the facility with a restorative nursing program. The ambulation program would consist of	F 0676		

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F 0676 SS=D	Continued from page 37 Resident 44 ambulating up to 100 feet with the use of a roller walker and contact guard assistance. Resident 44's clinical record did not contain evidence of an active restorative nursing program. The surveyor requested evidence of a restorative nursing program completed with Resident 44 during an interview with the Nursing Home Administrator and Employee 5 on March 5, 2025, at 2:00 PM. Review of nurse aide task documentation dated March 2025, revealed that the facility initiated a restorative nursing program for Resident 44's ambulation (after the surveyor's questioning) on March 5, 2025. Review of a plan of care developed by the facility on December 6, 2024, to address Resident 44's self-care deficits revealed that the facility initiated the intervention for Resident 44's restorative nursing program for ambulation on March 5, 2025.	F 0676		

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F 0676 SS=D	Continued from page 38 Interview with the Nursing Home Administrator on March 7, 2025, at 9:30 AM confirmed that the facility did not initiate a restorative nursing program to maintain Resident 44's ambulation skills following the termination of skilled therapy services. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services	F 0676		
F 0684 SS=D		F 0684		

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F 0684 SS=D	Continued from page 39 483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by:	F 0684	1. Resident 52 was not harmed and physician orders were updated to reflect plan of care. Resident 21 was not harmed and was reviewed. 2. The Director of Nursing reviewed residents physician orders to ensure accuracy. 3. The Director of Nursing educated nursing staff on the importance of issuing physician order in the residents' charts and to follow physician orders for the plan of care for each resident's needs. 4. The Director of Nursing or designee will complete weekly audits for four weeks then monthly for three months to ensure compliance that the physicians orders are being entered and completed for each residents needs. The Director of Nursing will bring audits to the monthly QA meeting for review.	Completion Date: 03/24/2025 Status: APPROVED Date: 03/18/2025

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F 0684 SS=D	Continued from page 40 Based on clinical record review and staff interview, it was determined that the facility failed to implement physician orders for two of 18 residents reviewed (Residents 52 and 21). Findings include: Clinical record review for Resident 52 revealed documentation by the facility's consultant optometrist (healthcare provider who specializes in eye care and vision services) dated January 21, 2025, that the provider evaluated Resident 52 for blurry vision in her right and left eyes. The provider diagnosed that Resident 52 had dry eye syndrome (tears are unable to provide adequate lubrication of the eye) of bilateral lacrimal glands (gland above the eye that produces tears), which was described as significant. The plan was to treat Resident 52 with one drop of artificial tears solution in both eyes twice a day. Resident 52's clinical record contained no evidence that staff implemented the eye care professional's	F 0684		

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F 0684 SS=D	Continued from page 41 directive to start artificial tears twice daily. Interview with the Nursing Home Administrator on March 7, 2025, at 9:22 AM confirmed that the facility failed to implement physician ordered artificial tears for Resident 52 following her appointment in January 2025. Clinical record review for Resident 21 revealed current physician orders for staff to obtain a daily weight. Review of Resident 21's weight documentation revealed that staff did not document their weight on the following dates: January 1, 5, 7, 15, 19, 24, and 26, 2025 February 1, 3, 4, 9, 17, 20, and 23, 2025 March 2, 2025 The above information during an interview on March 7, 2025, at 9:16 AM with the Nursing Home Administrator.	F 0684		

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F 0684 SS=D	Continued from page 42 483.25 Quality of Care Previously cited deficiency 4/19/24	F 0684		
F 0686 SS=D	28 Pa. Code 211.12(d)(1)(3)(5) Nursing services 483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by:	F 0686	1. Resident CR1 was discharged and was unharmed. 2. The Director of Nursing reviewed any current residents who have pressure ulcers to ensure proper treatments are in place and physician orders are being followed for proper wound care treatment. 3. The Director of Nursing provided education to the nursing staff regarding the significance of implementing appropriate wound care treatments and documentation tailored to each resident's needs and ensuring adherence to the established treatment plan. 4. The Director of Nursing or designee will complete weekly wound care audits for four weeks then monthly for three months and present the audits in the monthly QA meeting.	Completion Date: 03/24/2025 Status: APPROVED Date: 03/18/2025

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F 0686 SS=D	Continued from page 43 Based on closed clinical record review and staff interview, it was determined that the facility failed to provide recommended interventions, that are consistent with professional standards of practice, to promote healing of a pressure ulcer for one of two residents reviewed for pressure ulcers (Resident CR1). Findings include: Closed record review for Resident CR1 revealed the resident was admitted to the facility on December 27, 2024. The resident was discharged on January 6, 2025. Nursing documentation upon admission for Resident CR1 dated December 27, 2024, at 6:01 PM revealed the resident had a "Skin tear one centimeter in size to sacrum (a bone at the base of the spine)." An admission assessment for Resident CR1 titled "Admit/Readmit Screener V2," dated December 27,	F 0686		

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F 0686 SS=D	Continued from page 44 2024, at 6:27 PM revealed skin integrity documentation that assessed the resident as having moisture associated skin damage (MASD, damage to the skin caused by moisture), to the sacrum with measurements noted as one centimeter (cm) by 0.25 cm. Medical provider documentation for Resident CR1 dated January 2, 2025, at 5:57 PM revealed "No new concerns voiced by nursing staff." The skin was documented as assessed as "Warm and dry. No edema." There was no mention of the resident's skin tear on the sacrum as documented on admission by nursing staff. A skin and wound note from wound care (a third party wound management service that is contracted by the facility to perform various wound care needs/treatments/assessments) for Resident CR1 dated January 3, 2025, at 2:25 PM indicated "Resident is seen today for a comprehensive skin assessment. Noted sacral Stage 3 pressure injury (Full-thickness loss of skin, in which subcutaneous	F 0686		

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F 0686 SS=D	Continued from page 45 fat may be visible) to the sacrum. The size was documented as one cm x 0.5 cm x 0.2 cm. The wound base was assessed as 100 percent granulation (pink-red moist tissue that fills an open wound, when it starts to heal). The wound status was documented as "Present on admission." Treatment recommendations included: cleanse with wound cleanser, apply medical grade honey to base of the wound, secure with bordered foam, change every other day, and as needed. A review of the care plan for Resident CR1 noted the resident is at risk for skin integrity related to altered mobility and a Stage 3 pressure area to the sacrum. The care plan initiated date was March 7, 2025, which was after the resident was discharged from the facility. The associated interventions were also documented as created and initiated on March 7, 2025, after the resident was discharged from the facility. Further review of the physician orders for Resident CR1 revealed an order for "wound number one	F 0686		

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F 0686 SS=D	Continued from page 46 sacrum pressure treatment." Recommendations noted: cleanse with wound cleanser, apply medical grade honey to base of the wound, secure with bordered foam, change every other day, and as needed. The date of the order was January 6, 2025, with a start date of January 7, 2025, after the resident was discharged from the facility and four days after wound care assessed the resident's wound and made the initial recommendations. A review of the medication/treatment administration record (MAR/TAR, where staff document the administration of medications and treatments) for Resident CR1 for January 2025, revealed no evidence that the treatments were completed by the facility after being recommended by wound care on January 3, 2025. The facility could provide no further documentation or evidence that the recommendations were initiated in a timely manner as recommended by wound care, documented as completed, or staff were aware of these recommendations until after the resident was	F 0686		

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F 0686 SS=D	Continued from page 47 discharged from the facility. The above information for Resident CR1 was reviewed in a meeting with the Nursing Home Administrator on March 7 2025, at 1:35 PM. 28 Pa. Code 201.18(b)(1)(3) Management 28 Pa. Code 211.12(d)(1)(5) Nursing services	F 0686		
F 0695 SS=D		F 0695		

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F 0695 SS=D	Continued from page 48 483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by:	F 0695	1. Resident 54 tubing was changed immediately. Resident 36 tubing was changed immediately. 2. The Director of Nursing completed an audit on all residents requiring oxygen tubing including any needed devices that require oxygen tubing to be changed. 3. The Director of Nursing provided education to nursing staff to ensure all tubing is changed weekly. All residents requiring a tubing change is in the physician orders to be changed Every Saturday, nightshift. 4. The Director of Nursing and or designee will complete weekly random audits for four weeks and then monthly for three months to ensure tubing is being changed weekly. The Director of Nursing will bring audits to the monthly quality assurance meeting for review.	Completion Date: 03/24/2025 Status: APPROVED Date: 03/18/2025

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NAME OF PROVIDER OR SUPPLIER: SAYRE HEALTH CARE CENTER STATE LICENSE NUMBER: 192102		STREET ADDRESS, CITY, STATE, ZIP CODE: 151 KEEFER LANE SAYRE, PA 18840		
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F 0695 SS=D	Continued from page 49 Based on observation, clinical record review, and staff interview, it was determined that the facility failed to provide appropriate respiratory care and services for two of two residents reviewed (Residents 36 and 54). Findings include: According to the American Association for Respiratory Care proper cleansing of respiratory (nebulizer) equipment reduces infection risk. The longer a dirty nebulizer sits and is allowed to dry, the harder it is to clean thoroughly. Parts of the aerosol drug delivery device should be rinsed and then washed with soap and hot water after each treatment. Once completely dry, store the nebulizer cup and mouthpiece in a zip lock bag. Clinical record review for Resident 54 revealed a current physician's order for staff to provide oxygen at 2 liters per minute (LPM) via NC (nasal canula, tubing to deliver oxygen to the nose) continuously every shift, to change the oxygen tubing every	F 0695		

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F 0695 SS=D	Continued from page 50 Saturday night, label and date the new tubing for infection control, and make sure all tubing and nebulizer equipment (to help administer medication to the lungs) was bagged when not in use. Observation of Resident 54's room on March 4, 2025, at 11:47 AM, March 5, 2025, at 11:36 AM, and March 6, 2025, at 11:19 AM revealed that their oxygen concentrator was set at 2.5 LPM and that their nebulizer pipe was unbagged. The nebulizer tubing was dated February 23, 2025 (nine, 10, and 11 days prior to the observations). Concurrent interview with Resident 54 on March 6, 2025, revealed that staff was to change his tubing every week. Clinical record review for Resident 36 revealed current orders for staff to change the nebulizer tubing and bag every Saturday night shift. Staff are to label the tubing with the date, time, their initials, and make sure all tubing and nebulizer equipment was bagged when not in use.	F 0695		

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F 0695 SS=D	Continued from page 51 Observation of Resident 36's room on March 4, 2025, at 11:39 AM, March 5, 2025, at 8:29 AM, and March 6, 2025, at 8:25 AM and 11:17 AM revealed that their nebulizer pipe was unbagged\, and their tubing was dated February 23, 2025 (nine, 10, and 11 days prior to the observations). During each observation, there was an unopened bag dated February 23, 2025, lying on Resident 36's bedside stand and available for staff use. The above information was reviewed with the Nursing Home Administrator during an interview on March 6, 2025, at 9:16 AM. 28 Pa. Code 211.10 (c)(d) Resident care policies 28 Pa. Code 211.12(d)(1)(5) Nursing Services	F 0695		
F 0740 SS=D		F 0740		

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F 0740 SS=D	Continued from page 52 483.40 Behavioral Health Services §483.40 Behavioral health services. Each resident must receive and the facility must provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders. This REQUIREMENT is not met as evidenced by:	F 0740	<ol style="list-style-type: none"> Resident 44's care plan was updated to indicate behavioral health interventions. The Social Services Director reviewed the care plans of any residents with a behavior health concern and updated the care plans as needed to indicate behavioral health interventions. The Facility Administrator educated the social services department on the importance to list any behavior health interventions in the care plan to reflect the residents' needs and interventions. DON will add any interventions to the task section in PCC. The Facility Administrator or designee will complete weekly audits for four weeks then monthly for four months to ensure behavior health interventions are listed on the plan of care. These audits will be brought to the monthly QA meeting for review. 	Completion Date: 03/24/2025 Status: APPROVED Date: 03/18/2025

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F 0740 SS=D	Continued from page 53 Based on clinical record review and staff and resident interview, it was determined that the facility failed to provide behavioral health interventions for a resident to maintain the highest practicable mental well-being for one of two residents reviewed for behavioral concerns (Resident 44). Findings include: Clinical record review for Resident 44 revealed an admission MDS (Minimum Data Set, an assessment tool completed at specific intervals to determine resident care needs) dated December 13, 2024, that assessed that Resident 44 exhibited behavioral symptoms not directed towards others (e.g., physical symptoms such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily wastes, or verbal/vocal symptoms like screaming, disruptive sounds). Interview with Resident 44 on March 4, 2025, at 11:56 AM revealed that two staff provided her	F 0740		

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F 0740 SS=D	Continued from page 54 assistance to complete her most recent shower, and they were "slam bam," with the shower care. Resident 44 denied that staff were abusive but confirmed that she did not appreciate the approach staff used when providing her care. Resident 44 recounted this incident several times during the interview despite attempts to redirect her to other topics. Review of electronic Task Documentation (electronic system for nurse aides to document the provision of care) dated February 2025, revealed that Employee 3 (nurse aide) documented Resident 44 received a shower on Friday evening, February 28, 2025. Interview with Employee 3 on March 5, 2025, at 2:25 PM, revealed that she remembered Resident 44's shower experience on February 28, 2025. Employee 3 stated that another nurse aide, Employee 6, asked her to witness Resident 44's shower care because Resident 44 was known to make false accusations against staff. Employee 3	F 0740		

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F 0740 SS=D	Continued from page 55 stated that she witnessed Employee 6 begin to propel Resident 44 into the shower room via her wheelchair when Resident 44 began to get agitated stating that Employee 6 was hurting her shoulder (although Employee 6 had made no physical contact with Resident 44's body, only the handles of her wheelchair). Resident 44 began yelling at Employees 3 and 6 that they were going to damage her hearing aids in the shower although the hearing aids were in the charger in her room. Clinical record review for Resident 44 revealed a plan of care initiated December 7, 2024, that Resident 44 had a right to refuse care. Interventions included these instructions: "If resident becomes agitated or combative remove your self (sic) from resident and reattempt when at a later time when calmer," and "Staff will re-approach resident at a later time." A plan of care initiated by the facility on December 16, 2024, due to Resident 44's trigger for cognitive loss due to noted behaviors listed interventions that	F 0740		

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F 0740 SS=D	Continued from page 56 included, "Provide the resident with necessary cues, stop, and reapproach if agitated." The facility did not develop a care plan for Resident 44 that included an intervention that two staff should provide care due to her known behavior of false accusations. Staff failed to implement the interventions to stop care and reapproach Resident 44 when she exhibited agitated behaviors with false accusations. The surveyor reviewed the above concerns regarding Resident 44 during an interview with the Nursing Home Administrator and Employee 5 (director of rehab) on March 5, 2025, at 2:00 PM. 28 Pa. Code 211.12(d)(1)(5) Nursing services	F 0740		
F 0761 SS=D		F 0761		

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F 0761 SS=D	Continued from page 57 483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by:	F 0761	1. Resident 46 was not harmed. Facility Supervisor checked with Pharmacist about Resident 46's medication tablet and the Pharmacist indicated that the medication "could be crushed" in tablet form. Resident was not harmed due to the tablet of medication being crushed. 2. The Director of Nursing reviewed any residents who required medications to be crushed to ensure contraindications was labeled on the medication label. 3. The Director of Nursing educated the Nurses on the importance of reviewing medications for proper labeling and securing medications to ensure no pills are left on the floor. 4. The Director of Nursing and or designee will complete weekly random audits for one month and monthly audits for three months to ensure proper labeling and medications are secure. These audits will be brought to the monthly quality assurance monthly meeting.	Completion Date: 03/24/2025 Status: APPROVED Date: 03/18/2025

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F 0761 SS=D	Continued from page 58 Based on observation and staff interview, it was determined that the facility failed to securely store medications on one of two nursing units (Unit One dining room); and failed to ensure medication labeling for one of seven residents observed for medication administration (Resident 46). Findings include: Observation of a medication administration pass on March 5, 2025, at 9:01 AM revealed Employee 2 (licensed practical nurse, LPN) prepared medications for administration to Resident 46. Employee 2 crushed Resident 2's Rosuvastatin (medication used to lower cholesterol) 10 mg (milligram) tablet and administered the medication to Resident 46. The medication resource Drugs.com stipulated that a consumer should swallow a Rosuvastatin tablet whole. Interview with Employee 2 on March 5, 2025, at	F 0761		

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F 0761 SS=D	Continued from page 59 9:10 AM confirmed that she crushed Resident 46's Rosuvastatin medication. Employee 2 verified that there were no instructions on the medication labeling from the pharmacy that stipulated one should not crush the medication, and she was not aware of the precaution. Interview with Employee 1 (registered nurse) on March 5, 2025, at 9:12 AM indicated that the medication resource, Medline Plus, used by the facility's nursing staff, also stipulated that the medication Rosuvastatin should not be crushed. The facility failed to ensure that all medication labeling included appropriate precautionary instructions. Observation of the main dining area on Unit One on March 4, 2025, at 2:27 PM revealed a yellow-colored, round pill located on the floor behind a small television stand that was located underneath the wall-mounted television.	F 0761		

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F 0761 SS=D	Continued from page 60 An interview with Employee 2, LPN, on March 4, 2025, at 2:30 PM revealed the LPN was unable to identify the pill. The LPN proceeded to dispose of the medication. The above information for the pill found on the floor in the main dining area of Unit One was reviewed in a meeting with the Nursing Home Administrator on March 7, 2025, at 11:50 AM. 28 Pa. Code 211.9(f)(2)(k) Pharmacy services 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services	F 0761		
F 0791 SS=D		F 0791		

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F 0791 SS=D	Continued from page 61 483.55(b)(1)-(5) Routine/Emergency Dental Srvcs in NFs §483.55 Dental Services The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(b) Nursing Facilities. The facility- §483.55(b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(f) of this part, the following dental services to meet the needs of each resident: (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services; §483.55(b)(2) Must, if necessary or if requested, assist the resident- (i) In making appointments; and (ii) By arranging for transportation to and from the dental services locations; §483.55(b)(3) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay;	F 0791	1. Resident 52 received dental services. 2. The Facility Administrator completed a facility wide audit of current residents for dental services. 3. The Director of Nursing completed an education with nursing staff on ensuring that residents receive dental services. 4. The Facility Administrator and or designee will complete a weekly random audit for four weeks then monthly for three months and bring the completed audits for dental services to monthly QA meeting for review.	Completion Date: 03/24/2025 Status: APPROVED Date: 03/18/2025

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F 0791 SS=D	Continued from page 62 §483.55(b)(4) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; and §483.55(b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan. This REQUIREMENT is not met as evidenced by:	F 0791		

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F 0791 SS=D	Continued from page 63 Based on clinical record review, observation, and resident and staff interview, it was determined that the facility failed to obtain dental services for one of four residents reviewed for dental concerns (Resident 52). Findings include: Interview with Resident 52 on March 5, 2025, at 9:29 AM revealed that she utilized a partial dental plate to fill in the gap in her top teeth; however, that partial no longer fit. Resident 52 indicated that there were discussions regarding the replacement of the partial (between her son, the facility, and a dental provider), but she did not know if or when she would receive a new one. Observation of Resident 52 during the interview revealed that she had several missing front teeth. Clinical record review for Resident 52 revealed that Medicaid was a payer for her care as of August 23, 2024.	F 0791		

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F 0791 SS=D	Continued from page 64 Nursing documentation dated November 15, 2024, at 10:14 PM revealed that Resident 52 complained of left-sided dental pain. Staff assessed that the left side of Resident 52's face had visible swelling. Nursing documentation dated November 22, 2024, at 11:49 PM revealed that staff administered the antibiotic, Augmentin, for a dental infection. Resident 52's medical record contained no evidence that a professional dental provider evaluated Resident 52's diagnosed dental infection. Progress note documentation by the facility's contracted dental provider dated February 6, 2025, identified Resident 52 had cracked and missing teeth, a mesial drift (the natural inclination of teeth to shift toward the front of the mouth), and had a partial upper denture. The documentation confirmed that Resident 52 wanted a new partial denture; however, she had two teeth that were not restorable and had a root tip retained from a third tooth. Those teeth would need extracted prior to	F 0791		

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F 0791 SS=D	Continued from page 65 fabricating a new upper partial denture. Interview with the Nursing Home Administrator on March 7, 2025, at 9:22 AM confirmed that Resident 52 was admitted to the facility on March 13, 2024; however, the facility did not offer or obtain consent for professional dental services until July 10, 2024. The interview indicated that the facility had no evidence that Resident 52 received professional dental services for the almost year from March 13, 2024, to February 6, 2025, (despite Resident 52 had a dental infection that required antibiotics in November 2024). 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services	F 0791		
F 0812 SS=F		F 0812		

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F 0812 SS=F	Continued from page 66 483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by:	F 0812	1. No residents were harmed. 2. The dietary manager reviewed temp logs, immediately had housekeeping thoroughly clean the microwave and removed the expired Glucerna from the cabinet. 3. The Dietary Manager educated dietary staff on the importance of food temps, thoroughly cleaning the microwaves and discarding expired food/drinks. 4. The Dietary Manager or designee will audit these areas of concern. These audits will be completed weekly for four weeks then monthly for four and brought to the monthly QA meeting for review.	Completion Date: 03/24/2025 Status: APPROVED Date: 03/18/2025

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F 0812 SS=F	Continued from page 67 Based on observation and staff interview, it was determined that the facility failed to store, prepare, and serve food in a manner to prevent the potential spread of foodborne illness in the main kitchen and the facility's pantry for one of two nursing units (Unit 1 Nursing Unit). Findings include: According to HACCP (Hazard Analysis and Critical Control Points) to avoid the potential for food borne illness, food must be cooled from 135 degrees Fahrenheit to 70 degrees Fahrenheit within two hours, and from 70 degrees Fahrenheit to 41 degrees Fahrenheit or lower in the next four hours. Before cooling food, reduce the quantity or size of the food you are cooling by dividing large food items into smaller portions. Observation and review of the facility's cool down logs with Employee 4, certified dietary manager, on March 4, 2025, at 10:39 AM revealed that facility staff documented the following on February 28,	F 0812		

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F 0812 SS=F	Continued from page 68 2025: At 9:45 AM staff cooked four beef rounds and initiated cooling them down for food service at a later date. The beef rounds temperatures were documented as 178 degrees Fahrenheit, 202 degrees Fahrenheit, 199 degrees Fahrenheit, and 172 degrees Fahrenheit respectively. At 10:30 AM (45 minutes later) staff completed four beef round temperatures that were documented as 146 degrees Fahrenheit, 140 degrees Fahrenheit, 137 degrees Fahrenheit, and 147 degrees Fahrenheit respectively. At 11:30 AM (1 hour and 45 minutes later) staff completed four beef round temperatures that were documented as 100 degrees Fahrenheit, 85 degrees Fahrenheit, 76 degrees Fahrenheit, and 89 degrees Fahrenheit respectively. At 12:30 AM (2 hours and 45 minutes later) staff completed four beef round temperatures that were	F 0812		

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F 0812 SS=F	Continued from page 69 documented as 69 degrees Fahrenheit, 61 degrees Fahrenheit, 66 degrees Fahrenheit, and 64 degrees Fahrenheit respectively. There was no other documentation that indicated staff completed any further cool down temperatures on the four beef rounds. There was no documentation that the four beef rounds reached 40 degrees Fahrenheit, a safe food holding temperature, within a total of four hours after reaching 70 degrees Fahrenheit and within a total of six hours after the potentially hazardous food cool down was initiated. Review of the facility's food service temperature logs dated March 2, 2025, revealed that the facility served the above noted beef rounds as roast beef to residents. Concurrent interview with Employee 4 acknowledged the beef round cool down temperature documentation and subsequent usage.	F 0812		

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F 0812 SS=F	Continued from page 70 Observation of the Unit 1 Nursing pantry on March 5, 2025, at 9:35 AM revealed that the microwave had dried, stuck-on food on the walls and ceiling. In a lower cabinet to the left of the refrigerator, there were 12 cartons of vanilla Glucerna (a food supplement) with a use by date of February 1, 2025, that were available for resident use. Interview and observation of the Unit 1 Nursing pantry with Employee 4 on March 5, 2025, at 9:41 AM confirmed the above information. The above concerns were reviewed with the Nursing Home Administrator during an interview on March 5, 2025, at 2:15 PM. 483.60(i)(1)(2) Food Procurement. store/prepare/serve Sanitary Previously cited 4/19/24 28 Pa. Code 201.14 (a) Responsibility of licensee.	F 0812		
F 0880 SS=D		F 0880		

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F 0880 SS=D	<p>Continued from page 71</p> <p>483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control</p> <p>§483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.</p> <p>§483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:</p> <p>§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards;</p> <p>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported;</p>	F 0880	<ol style="list-style-type: none"> 1. Resident 75 was immediately placed on Enhanced Barrier Precautions with isolation set up. 2. The Director of Nursing and IP reviewed all residents in need of EBP to ensure they had the proper isolation signage and set up. 3. The Director of Nursing completed an education with the nursing department to ensure EBP is in place for any residents who are contraindicated for Enhanced Barrier Precautions. 4. The Director of Nursing or designee will complete weekly random audits for four weeks then monthly for four months and bring the EBP audits to the monthly QA meeting for review. 	<p>Completion Date: 03/24/2025 Status: APPROVED Date: 03/18/2025</p>

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F 0880 SS=D	Continued from page 72 (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by:	F 0880		

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F 0880 SS=D	Continued from page 73	F 0880		

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F 0880 SS=D	Continued from page 74 Based on observation, clinical record review, and resident and staff interview, it was determined that the facility failed to implement appropriate enhanced barrier transmission-based precautions for one of 18 residents reviewed (Resident 75) Findings include: Review of the memo entitled "Enhanced Barrier Precautions (EBP, gown and glove use) in Nursing Homes to Prevent the Spread of Multi-drug Resistant Organisms" released by the Center for Medicaid and Medicare Services (CMS) on March 20, 2024, with an implementation date of April 1, 2024, revealed that nursing care facilities are to use EBP for residents with chronic wounds or indwelling medical devices during high-contact resident care activities regardless of their multidrug-resistant organism status. High-contact activity would include things like dressing, transferring, changing linens, providing hygiene, changing briefs, wound care, or device care.	F 0880		

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F 0880 SS=D	Continued from page 75 Review of the facility policy titled, "Infection Prevention Control 2024 Plan," last reviewed without changes on June 13, 2024, revealed that EBP are an infection control intervention designed to reduce transmission of multi-drug resistant organisms (MDRO, bacteria that resist treatment to antibiotics) through gown and glove use by healthcare professionals in long-term care settings in accordance with the Centers for Disease Control and Prevention (CDC) consideration for use of EBP in skilled nursing facilities. EBP are recommended during high contact care (dressing, bathing, transferring, changing brief or assisting with toileting, device care, wound care, etc.) activities with residents who are at higher risk of acquiring or spreading and MDRO (residents with indwelling medical devices or wounds). EBP should be followed (when contact precautions do not otherwise apply) for residents with any of the following: open wounds requiring a dressing change, indwelling medical devices (central line, urinary catheter, feeding tubes, etc., tracheostomy/ventilator) regardless of MDRO	F 0880		

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F 0880 SS=D	Continued from page 76 status. Clinical record review for Resident 75 revealed a current physician's order dated February 19, 2025, for hemodialysis (treatment for kidney failure; an external medical device that filters extra fluid and waste products from the blood) on Monday, Wednesday, and Friday at 11:00 AM. Nursing documentation for Resident 75 dated February 17, 2025, at 9:57 PM revealed the resident was admitted and had a tunneled dialysis catheter to the right chest. Hospital documentation dated February 5 to 17, 2025, revealed the resident had a tunneled dialysis catheter placed to the right chest wall. Further review of the clinical record revealed no evidence to indicate that Resident 75 was on any type of enhanced barrier precautions. Observation of Resident 75 on March 7, 2025, at	F 0880		

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F 0880 SS=D	Continued from page 77 11:15 AM revealed no evidence that the resident was on EBP (no sign indicating EBP precautions, no personal protective equipment (PPE) in the room or at the doorway to don, or any sign placed that instructed to see the nurse prior to care). A concurrent interview with the resident with Employee 1, registered nurse, at the bedside, confirmed that the resident does have a tunneled dialysis catheter in the right upper chest. An interview with the Nursing Home Administrator on March 7, 2025, at 12:23 PM revealed that the resident was not on EBP; however, is supposed to be on them per the facility policy. 483.80(a)(1)(2)(4)(e)(f) Infection Prevention and Control Previously cited deficiency 4/19/24 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	F 0880		

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F 0922 SS=D	483.90(i)(1) Procedures to Ensure Water Availability The facility must-- §483.90(i)(1) Establish procedures to ensure that water is available to essential areas when there is a loss of normal water supply; This REQUIREMENT is not met as evidenced by:	F 0922	1. Expired was immediately discarded. 2. The Dietary Manager completed an audit of all emergency water to ensure no other water was expired. Dietary Manager ordered more water to replenish expired water. 3. The Dietary Manager educated the dietary department to check emergency water supply and discard of water that is expired and to note to the Dietary Manager to order to replenish. 4. The Dietary Manager or designee will completed weekly random audits for four weeks and then monthly for three months and bring emergency water supply audits to the monthly QA meeting.	Completion Date: 03/24/2025 Status: APPROVED Date: 03/18/2025

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F 0922 SS=D	Continued from page 79 Based on review of select facility policy and procedures, observation, and staff interview, it was determined that the facility failed to follow established procedures of water storage to ensure that water is available to essential areas when there is a loss of normal water supply for two of two nursing units (Unit 1 and Unit 2). Findings include: A review of the facility policy titled, "Water Availability," last reviewed without changes on June 13, 2024, revealed that the facility will ensure water availability to essential areas when there is a loss of normal water supply. Further review of the policy revealed that, "This water will be rotated on a regular basis." Observation of a storage area on Nursing Unit 1 across from the main dining area on March 5, 2025, at 9:56 AM revealed a large shelving unit that held multiple cardboard boxes. Each cardboard box contained six gallons of water.	F 0922		

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F 0922 SS=D	Continued from page 80 A concurrent interview with Employee 8, medical records and human resources, revealed the boxes containing the gallons of water were the facility's emergency water supply. Further observation of the boxes of water revealed six of the nine boxes reviewed were past the manufacturer's best by dates. Two boxes had a best by date of July 31, 2024, and four of the boxes had a best buy date of August 31, 2024. The associated dates were also stamped near the top of each gallon of water. An interview with the Nursing Home Administrator on March 5, 2025, at 10:04 AM revealed it was unclear why the expired boxes of water had not been disposed of. An interview with Employee 4, certified dietary manager, on March 5, 2025, at 10:06 AM revealed that additional boxes of water for the emergency supply were also kept in storage in the facility's main	F 0922		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0922 SS=D	Continued from page 81 kitchen area. Observation of these additional boxes of water with Employee 4 on March 5, 2025, at 10:10 AM revealed multiple boxes of water stored in the dry goods storage section of the facility's main kitchen. Four of the 10 boxes of water reviewed revealed that the boxes were past the expiration dates: three boxes of water were dated with a best by date of July 31, 2024; and one box of water had a past best by date of September 30, 2024. There was no further evidence provided by the facility to ensure that the emergency water supply was rotated on a regular basis, as indicated in the facility's policy and procedure, to ensure water that was past the best by date was removed from the supply. 28 Pa. Code 201.18(b)(1) Management	F 0922		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395101	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 03/07/2025	
NAME OF PROVIDER OR SUPPLIER: SAYRE HEALTH CARE CENTER STATE LICENSE NUMBER: 192102		STREET ADDRESS, CITY, STATE, ZIP CODE: 151 KEEFER LANE SAYRE, PA 18840		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
P 5520	Nursing services. (3) Effective July 1, 2024, a minimum of 1 nurse aide per 10 residents during the day, 1 nurse aide per 11 residents during the evening, and 1 nurse aide per 15 residents overnight. This REGULATION is not met as evidenced by:	P 5520	1. Nursing Staff care hours will be reviewed daily for the current day and for the remainder of the week during morning meeting for compliance with current regulations of a minimum of 1 CNA per 10 Residents during the day and 1 CNA per 11 residents evening shift and 1 CNA per 15 Residents on the overnight shift 2. Will continue to actively hire and advertise open positions to meet current regulations. 3. The facility will continue to use per diem staff to fill in open shifts and ask current LPNs, current CNAs and RNs to fill in open CNA shifts 4.DON/designee will complete weekly audits on CNA staffing ratio for four weeks and then monthly for three months and bring to the monthly QA meeting for review.	Completion Date: 03/24/2025 Status: APPROVED Date: 03/18/2025
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE:		(X6) DATE:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395101	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 03/07/2025
NAME OF PROVIDER OR SUPPLIER: SAYRE HEALTH CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: 151 KEEFER LANE SAYRE, PA 18840		
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P 5520	Continued from page 1 Based on a review of nursing staffing hours and staff interview, it was determined that the facility failed to ensure a minimum of one nurse aide per 10 residents on five of 21 day shifts reviewed; a minimum of one nurse aide per 10 residents on four of 21 evening shifts reviewed; and failed to ensure a minimum of one nurse aide per 15 residents on nine of 21 overnight shifts reviewed. Findings include: Review of nursing staff care hours provided by the facility for October 13 to 19, 2024, December 29, 2024, through January 4, 2025, and February 28, 2025, through March 6, 2025, revealed the following nurse aides (NA) scheduled for the resident census: Day shift: October 13, 2024, 6.38 NAs for a census of 75, requires 7.5 NAs. October 14, 2024, 3.28. NAs for a census of 74,	P 5520		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395101	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 03/07/2025
NAME OF PROVIDER OR SUPPLIER: SAYRE HEALTH CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: 151 KEEFER LANE SAYRE, PA 18840		
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
P 5520	Continued from page 2 requires 7.4 NAs. December 31, 2024, 7 NAs for a census of 76, requires 7.6 NAs. January 1, 2025, 7.38 NAs for a census of 76, requires 7.6 NAs. January 4, 2025, 6 NAs for a census of 78, requires 7.8 NAs. Evening shift: December 30, 2024, 6.34 NAs for a census of 76, requires 6.91 NAs. January 1, 2025, 6.38 NAs for a census of 76, requires 6.91 NAs. January 4, 2025, 5.72 NAs for a census of 75, requires 6.82 NAs. March 3, 2025, 5 NAs for a census of 73, requires 6.64 NAs.	P 5520		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395101	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 03/07/2025
NAME OF PROVIDER OR SUPPLIER: SAYRE HEALTH CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: 151 KEEFER LANE SAYRE, PA 18840		
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P 5520	Continued from page 3 Overnight shift: October 14, 2024, 4.38 NAs for a census of 74, requires 4.93 NAs. October 16, 2024, 4.69 NAs for a census of 74, requires 4.93 NAs. December 29, 2024, 5.03 NAs for a census of 78, requires 5.2 NAs. December 30, 2024, 4.47 NAs for a census of 76, requires 5.07 NAs. December 31, 2024, 4.03 NAs for a census of 76, requires 5.07 NAs. January 2, 2025, 5 NAs for a census of 78, requires 5.2 NAs. January 3, 2025, 4.84 NAs for a census of 78, requires 5.2 NAs. January 4, 2025, 3.91 NAs for a census of 75, requires 5.0 NAs. March 6, 2025, 4 NAs for a census of 71, requires 4.73 NAs.	P 5520		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395101	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 03/07/2025
NAME OF PROVIDER OR SUPPLIER: SAYRE HEALTH CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: 151 KEEFER LANE SAYRE, PA 18840		
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P 5520	Continued from page 4	P 5520		
P 5530	<p>This information was reviewed during an interview with the Nursing Home Administrator on March 7, 2025, at 1:40 PM.</p> <p>Nursing services.</p> <p>(4) Effective July 1, 2023, a minimum of 1 LPN per 25 residents during the day, 1 LPN per 30 residents during the evening, and 1 LPN per 40 residents overnight.</p> <p>This REGULATION is not met as evidenced by:</p>	P 5530	<ol style="list-style-type: none"> 1. Nursing Staff care hours will be reviewed daily for the current day and for the remainder of the week during morning meeting for compliance with current regulations of a minimum of 1 LPN for 25 Residents during the day, 1 LPN per 30 Residents during the evening shift and 1 LPN per 40 Residents on overnight shift. 2. Will continue to actively hire and advertise open positions to meet current regulations. 3. The facility will continue to use per diem staff to fill in open shifts and ask current LPNs, and RNs to fill in open LPN shifts. 4. DON/designee will complete weekly audits on LPN staffing ratio for four weeks and then monthly for three months and bring to the monthly QA meeting for review. 	<p>Completion Date: 03/24/2025 Status: APPROVED Date: 03/18/2025</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395101	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 03/07/2025
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P 5530	Continued from page 5 Based on a review of nursing staffing hours and staff interview, it was determined that the facility failed to ensure a minimum of one licensed practical nurse (LPN) per 25 residents on eight of 21 day shifts reviewed; a minimum of one LPN per 30 residents on eight of 21 evening shifts reviewed; and failed to ensure a minimum of one LPN per 40 residents on three of 21 days reviewed. Findings include: Review of nursing staff care hours provided by the facility for October 13 to 19, 2024, December 29, 2024, through January 4, 2025, and February 28, 2025, through March 6, 2025, revealed the following LPN scheduled for the following resident census: Day shift: October 18, 2024, 3.03 LPNs for a census of 76, requires 3.04 LPNs.	P 5530		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395101	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 03/07/2025
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P 5530	Continued from page 6 December 29, 2024, 3.06 LPNs for a census of 78, requires 3.12 LPNs. December 30, 2024, 2.97 LPNs for a census of 76, requires 3.04 LPNs. December 31, 2024, 2.97 LPNs for a census of 76, requires 3.04 LPNs. January 1, 2025, 2.94 LPNs for a census of 78, requires 3.12 LPNs. January 3, 2025, 2.97 LPNs for a census of 78, requires 3.12 LPNs. January 4, 2025, 3.03 LPNs for a census of 78, requires 3.12 LPNs. February 7, 2025, 4.28 LPNs for a census of 109, requires 4.36 LPNs. Evening shift: January 22, 2025, 3.13 LPNs for a census of 106, requires 3.53 LPNs. January 24, 2025, 3.01 LPNs for a census of 109, requires 3.63 LPNs.	P 5530		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395101	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 03/07/2025
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P 5530	Continued from page 7 January 25, 2025, 3.59 LPNs for a census of 109, requires 3.63 LPNs. January 26, 2025, 3.13 LPNs for a census of 106, requires 3.53 LPNs. February 7, 2025, 2.93 LPNs for a census of 109, requires 3.63 LPNs. February 9, 2025, 2.84 LPNs for a census of 108, requires 3.63LPNs. February 18, 2025, 3.2 LPNs for a census of 106, requires 3.53 LPNs. February 20, 2025, 3.5 LPNs for a census of 106, requires 3.53 LPNs. Overnight shift: January 24, 2025, 2.68 LPNs for a census of 109, requires 2.73 LPNs. January 25, 2025, 2.56 LPNs for a census of 109, requires 2.73 LPNs. February 10, 2025, 2.63 LPNs for a census of 108, requires 2.7 LPNs.	P 5530		

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P 5530	Continued from page 8	P 5530		
P 5640	<p>This information was reviewed during an interview with the Nursing Home Administrator on March 7, 2025, at 1:40 PM.</p> <p>Nursing services.</p> <p>(2) Effective July 1, 2024, the total number of hours of general nursing care provided in each 24-hour period shall, when totaled for the entire facility, be a minimum of 3.2 hours of direct resident care for each resident.</p> <p>This REGULATION is not met as evidenced by:</p>	P 5640	<ol style="list-style-type: none"> 1. Nursing Staff PPD care hours will be reviewed daily for the current day and for the remainder of the week during morning meeting for compliance with the state regulation of the nursing hours guidance for a staff PPD of 3.2. 2. The facility will continue to actively hire and advertise open positions to meet current regulations. 3. The facility will continue to use per diem staff to fill open shifts and ask current RN's, LPN's and CNA's to fill open shifts. 4. DON and or designee will review PPD staffing hour weekly for four works then monthly three months and bring audits to the monthly QA meeting for review. 	<p>Completion Date: 03/24/2025 Status: APPROVED Date: 03/18/2025</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395101	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 03/07/2025
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P 5640	Continued from page 9 Based on review of nursing staffing hours and staff interview, it was determined that the facility failed to ensure the total of nursing care hours provided in each 24-hour period was a minimum of 3.2 hours per patient day (PPD), effective July 1, 2024, for eight of the 21 days reviewed. Findings include: Review of nursing staff care hours provided by the facility for October 13 to 19, 2024, December 29, 2024, through January 4, 2025, and February 28, 2025, through March 6, 2025, revealed that the facility failed to meet the minimum hours per patient day on the following dates: October 13, 2024, with 3.11 hours per resident per day. October 14, 2024, with 2.79 hours per resident per day. December 29, 2024, with 3.18 per resident per day.	P 5640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395101	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 03/07/2025
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P 5640	Continued from page 10 December 30, 2024, with 3.13 per resident per day. December 31, 2024, with 2.99 per resident per day. January 2, 2025, with 3.18 hours per resident per day January 3, 2025, with 3.19 hours per resident per day January 4, 2025, with 2.74 hours per resident per day The facility failed to meet the required nursing staffing PPD. This information was reviewed during an interview with the Nursing Home Administrator on March 7, 2025, at 1:40 PM.	P 5640		

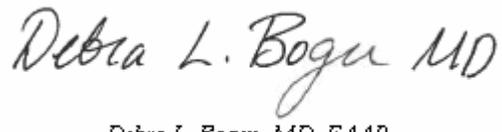


Certified End Page

SAYRE HEALTH CARE CENTER
STATE LICENSE NUMBER: 192102
SURVEY EXIT DATE: 03/07/2025

I Certify This Document to be a True and Correct Statement of Deficiencies and Approved Facility Plan of Correction for the Above-Identified Facility Survey


Jeanne Parisi
Deputy Secretary for Quality Assurance


Debra L. Bogen, MD, FAAP
Secretary of Health



Pennsylvania
Department of Health

THIS IS A CERTIFICATION PAGE

PLEASE DO NOT DETACH

THIS PAGE IS NOW PART OF THIS SURVEY