

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395228	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/18/2025
NAME OF PROVIDER OR SUPPLIER: COLE PLACE		STREET ADDRESS, CITY, STATE, ZIP CODE: 1001 EAST SECOND STREET COUDERSPORT, PA 16915		
STATE LICENSE NUMBER: 031802				
(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 0550 SS=D	Based on a Medicare/Medicaid Recertification Survey, State Licensure Survey, and Civil Rights Compliance Survey, completed on April 18, 2025, it was determined that Cole Place 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 0550		

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395228	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/18/2025
NAME OF PROVIDER OR SUPPLIER: COLE PLACE STATE LICENSE NUMBER: 031802		STREET ADDRESS, CITY, STATE, ZIP CODE: 1001 EAST SECOND STREET COUDERSPORT, PA 16915		
(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 0550 SS=D	Continued from page 1 483.10(a)(1)(2)(b)(1)(2) Resident Rights/Exercise of Rights §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.	F 0550	The Facility submits this Plan of Correction under procedures established by the Department of Health in order to comply with the Department's directive to change conditions which the Department alleges is deficient under State and/or Federal Long Term Care Regulations. This Plan of Correction should not be construed as either a waiver of the facility's right to appeal or challenge the accuracy or severity of the alleged deficiencies or an admission of past or ongoing violation of State or Federal regulatory requirements. 1. Resident 3 's care plan reflects her preference to occasionally wear hospital gowns depending on her preference each day. Resident 3 and resident 11 had their clean laundry returned to them. 2. All residents using facility laundry services will have closets checked for clothing that allows for seven outfits or per resident's preference.	Completion Date: 05/22/2025 Status: APPROVED Date: 05/08/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395228	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/18/2025
NAME OF PROVIDER OR SUPPLIER: COLE PLACE STATE LICENSE NUMBER: 031802		STREET ADDRESS, CITY, STATE, ZIP CODE: 1001 EAST SECOND STREET COUDERSPORT, PA 16915		
(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 0550 SS=D	Continued from page 2 §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by:	F 0550	3. Social Worker and CNAs will be educated to report concerns with availability of clean clothes for residents. 4. Social Worker or designee will complete random audits on 5 residents per week to ensure the resident has the availability of resident's clean clothes. Audits will be completed weekly x4 then monthly x2 with results reported to QAPI.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395228	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/18/2025
NAME OF PROVIDER OR SUPPLIER: COLE PLACE STATE LICENSE NUMBER: 031802		STREET ADDRESS, CITY, STATE, ZIP CODE: 1001 EAST SECOND STREET COUDERSPORT, PA 16915		
(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 0550 SS=D	Continued from page 3 Based on observation and resident and staff interviews, it was determined that the facility failed to ensure that care and services were provided in a manner that enhanced resident dignity for two of nine residents sampled (Resident 3 and 11). Findings include: Observation of Resident 3 on April 15, 2025, at 10:20 AM revealed she was in bed in a hospital gown. Resident 3 stated she doesn't have any clothes to wear. She stated that they send her laundry out to get laundered and she does not receive it back timely. Observation of Resident 3's closet at this time revealed there was one shirt hanging in the closet and no pants. Observation of Resident 3 on April 16, 2025, at 10:32 AM revealed she was in bed with a hospital gown on. Resident 3 revealed her clothes have not been returned from laundry. Observation of Resident 11 on April 15, 2025, at	F 0550		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395228	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/18/2025
NAME OF PROVIDER OR SUPPLIER: COLE PLACE STATE LICENSE NUMBER: 031802		STREET ADDRESS, CITY, STATE, ZIP CODE: 1001 EAST SECOND STREET COUDERSPORT, PA 16915		
(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 0550 SS=D	Continued from page 4 11:37 AM revealed she was in bed in a hospital gown. Resident 11 stated she was wearing a hospital gown due to not receiving her laundry back. She stated she frequently runs out of clothes. She stated the facility sends her personal laundry out of the facility to be laundered and it takes a long time to get her clothes back. Observation of Resident 3's closet at this time revealed no clothes. Observation of Resident 11 on April 16, 2025, at 10:11 AM revealed she was in bed with a hospital gown on. Observation of Resident 11's closet again revealed no clothes. Interview with Employee 4 (environmental services manager) and Employee 5 (operations manager) on April 18, 2025, at 9:28 AM confirmed that the residents' personal laundry gets sent out of the facility to be laundered. They stated that the laundry is collected in resident rooms and picked up from the contracted company four times a week. Employee 4 stated there is no specific timeframe when the laundry is returned. Employee 4 stated it	F 0550		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395228	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/18/2025
NAME OF PROVIDER OR SUPPLIER: COLE PLACE STATE LICENSE NUMBER: 031802		STREET ADDRESS, CITY, STATE, ZIP CODE: 1001 EAST SECOND STREET COUDERSPORT, PA 16915		
(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 0550 SS=D	Continued from page 5 is usually once a week, but sometimes not all the laundry is returned at the same time. Employees 5 stated residents are expected to have 14 days' worth of clothes, but stated there is no facility protocol to ensure residents' have enough clothes. Interview with the Nursing Home Administrator and Director of Nursing on April 18, 2025, at 10:04 AM confirmed the above findings. The facility failed to ensure residents' dignity related to personal laundry. 28 Pa. Code 201.18(b)(1) Management	F 0550		
F 0578 SS=D		F 0578		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395228	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/18/2025
NAME OF PROVIDER OR SUPPLIER: COLE PLACE STATE LICENSE NUMBER: 031802		STREET ADDRESS, CITY, STATE, ZIP CODE: 1001 EAST SECOND STREET COUDERSPORT, PA 16915		
(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 0578 SS=D	Continued from page 6 483.10(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	The Facility submits this Plan of Correction under procedures established by the Department of Health in order to comply with the Department's directive to change conditions which the Department alleges is deficient under State and/or Federal Long Term Care Regulations. This Plan of Correction should not be construed as either a waiver of the facility's right to appeal or challenge the accuracy or severity of the alleged deficiencies or an admission of past or ongoing violation of State or Federal regulatory requirements. 1. Resident 118's physician order and banner notification were updated to reflect resident 118's desire for CPR and refusal of intubation (i.e. DNI). There was no harm to resident 118. 2. All current resident records will be reviewed to ensure that the Banner Bar and the physician order, which may also reflect any limited interventions (such as intubation)	Completion Date: 05/22/2025 Status: APPROVED Date: 05/08/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395228	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/18/2025
NAME OF PROVIDER OR SUPPLIER: COLE PLACE STATE LICENSE NUMBER: 031802		STREET ADDRESS, CITY, STATE, ZIP CODE: 1001 EAST SECOND STREET COUDERSPORT, PA 16915		
(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 0578 SS=D	Continued from page 7 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	match the residents code preferences noted on the POLST and/or the Advanced Directive as indicated. 3. The DON or Designee will Educate all RNs, LPNS, and Social Worker on the need to ensure that the Banner Bar and the physician order, which may also reflect any limited interventions (such as intubation) match the residents code preferences noted on the POLST and/or the Advanced Directive as indicated. 4. Social worker or designee will audit to ensure that the Banner Bar and the physician order, which may also reflect any limited interventions (such as intubation) match the residents code preferences noted on the POLST and/or the Advanced Directive as indicated. 5 resident charts will be audited weekly x4 then 5 resident charts will be audited monthly x2 or until substantial compliance is achieved. Results will be reported at the QAPI meeting.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395228	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/18/2025	
NAME OF PROVIDER OR SUPPLIER: COLE PLACE STATE LICENSE NUMBER: 031802		STREET ADDRESS, CITY, STATE, ZIP CODE: 1001 EAST SECOND STREET COUDERSPORT, PA 16915		
(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 0578 SS=D	Continued from page 8 Based on clinical record review and staff interview it was determined that the facility failed to establish clear and consistent resident wishes regarding advance directives for one of one resident reviewed for advance directive concerns (Resident 118). Findings include: Clinical record review of Resident 118's physical chart revealed a POLST (Physician Orders for Life-Sustaining Treatment, portable medical order form that records residents' treatment wishes so that emergency personnel know what treatment the resident wants in the event of a medical emergency) signed by a physician on April 8, 2025, and signed by Resident 118 that indicated Resident 118 desired CPR (Full Code, cardiopulmonary resuscitation, chest compressions and artificial breathing assistance upon a medical emergency and/or death); however, limited other interventions such as refusing intubation (DNI, do not insert a tube into the airway to help with breathing).	F 0578		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395228	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/18/2025
NAME OF PROVIDER OR SUPPLIER: COLE PLACE STATE LICENSE NUMBER: 031802		STREET ADDRESS, CITY, STATE, ZIP CODE: 1001 EAST SECOND STREET COUDERSPORT, PA 16915		
(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 0578 SS=D	Continued from page 9 Review of active physician orders in Resident 118's electronic medical record instructed staff to implement Full Code treatment. Interview with Employee 1 (registered nurse) on April 16, 2025, at 1:52 PM revealed that should Resident 118 have a medical emergency, she would refer to his electronic medical record (EMR), note that it did not indicate DNR (Do Not Resuscitate) in the top banner of the screen, and initiate cardiopulmonary resuscitation without any limitations. Employee 1 confirmed that the information she reviewed in Resident 118's electronic medical record did not prohibit intubation. Employee 1 confirmed that current physician orders for Resident 118 instructed staff to implement Full Code treatment. Interview with Employee 2 (registered nurse) on April 16, 2025, at 1:56 PM revealed that she would go to Resident 118's EMR first. Employee 2 reviewed Resident 118's EMR chart and said that because it did not note DNR, she would assume she	F 0578		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395228	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/18/2025
NAME OF PROVIDER OR SUPPLIER: COLE PLACE STATE LICENSE NUMBER: 031802		STREET ADDRESS, CITY, STATE, ZIP CODE: 1001 EAST SECOND STREET COUDERSPORT, PA 16915		
(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 0578 SS=D	Continued from page 10 was to implement Full Code treatment. The surveyor reviewed Resident 118's POLST contained in Resident 118's physical chart with Employee 2 who confirmed that the limited interventions to not intubate were not reflected in the EMR physician orders. The surveyor reviewed the DNI omission from Resident 118's electronic physician orders during an interview with the Director of Nursing on April 17, 2025, at 3:44 PM. The facility revised Resident 118's physician order on April 18, 2025 (following the surveyor's questioning) to include the additional instructions to not use intubation. 28 Pa. Code 201.18(b)(1) Management 28 Pa. Code 201.29(a) Resident rights 28 Pa. Code 211.12(d)(1)(5) Nursing services	F 0578		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395228	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/18/2025
--	---	---	--

NAME OF PROVIDER OR SUPPLIER: COLE PLACE STATE LICENSE NUMBER: 031802	STREET ADDRESS, CITY, STATE, ZIP CODE: 1001 EAST SECOND STREET COUDERSPORT, PA 16915
---	--

(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 0684 SS=D		F 0684		
--------------------	--	--------	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395228	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/18/2025
NAME OF PROVIDER OR SUPPLIER: COLE PLACE STATE LICENSE NUMBER: 031802		STREET ADDRESS, CITY, STATE, ZIP CODE: 1001 EAST SECOND STREET COUDERSPORT, PA 16915		
(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 0684 SS=D	Continued from page 12 483.25 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	The Facility submits this Plan of Correction under procedures established by the Department of Health in order to comply with the Department's directive to change conditions which the Department alleges is deficient under State and/or Federal Long Term Care Regulations. This Plan of Correction should not be construed as either a waiver of the facility's right to appeal or challenge the accuracy or severity of the alleged deficiencies or an admission of past or ongoing violation of State or Federal regulatory requirements. 1. Resident 12's new right-hand splint arrived before the exit conference. Staff on duty at the time were verbally re-educated on the splint schedule (which specifies when to apply and remove the hand splint) for this resident. Resident was wearing splint as directed without difficulty. The plan of care was reviewed and updated as indicated.	Completion Date: 05/22/2025 Status: APPROVED Date: 05/08/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395228	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/18/2025
NAME OF PROVIDER OR SUPPLIER: COLE PLACE STATE LICENSE NUMBER: 031802		STREET ADDRESS, CITY, STATE, ZIP CODE: 1001 EAST SECOND STREET COUDERSPORT, PA 16915		
(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 0684 SS=D	Continued from page 13	F 0684	<p>2. All residents with hand splints were reviewed to ensure the splint was present and in good repair. Staff also reviewed the current hand splint schedule (which specifies when to apply and remove the hand splint). The plan of care was reviewed and updated as indicated.</p> <p>3. The Director of Nursing and/ or designee will educate the RNs, LPNs and CNAs on the need to ensure splints are present and in good repair and where to note the current hand splint schedule.</p> <p>4. DON or designee will audit residents with hand splints to ensure splints are on as per the plan of care and good repair weekly x4 then monthly x2 or until substantial compliance is achieved. Results will be reviewed at the QAPI meeting.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395228	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/18/2025	
NAME OF PROVIDER OR SUPPLIER: COLE PLACE STATE LICENSE NUMBER: 031802		STREET ADDRESS, CITY, STATE, ZIP CODE: 1001 EAST SECOND STREET COUDERSPORT, PA 16915		
(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 0684 SS=D	Continued from page 14 Based on clinical record review, observation, and staff interview, it was determined that the facility failed to ensure the appropriate implementation of a physician ordered positioning device for one of three residents reviewed for positioning and mobility concerns (Resident 12). Findings include: Clinical record review for Resident 12 revealed a quarterly MDS (Minimum Data Set, an assessment tool completed at specific intervals to determine resident care needs) dated January 8, 2025, that assessed that he had range of motion (ROM) impairment of his bilateral upper extremities (included shoulder, elbow, wrist, and hand). An active physician's order dated January 8, 2025, instructed staff to apply a splint to Resident 12's right hand per a schedule of: on at bedtime, removed at breakfast, back on after lunch, and off at dinner.	F 0684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395228	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/18/2025
NAME OF PROVIDER OR SUPPLIER: COLE PLACE STATE LICENSE NUMBER: 031802		STREET ADDRESS, CITY, STATE, ZIP CODE: 1001 EAST SECOND STREET COUDERSPORT, PA 16915		
(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 0684 SS=D	Continued from page 15 Review of a plan of care developed by the facility to address Resident 12's decline in ROM due to contractures (changes to muscles, tendons, and skin that causes stiffness, pain, and loss of movement) that required a restorative nursing program (RNP) for a splint/brace to his right hand revealed that staff were to apply the splint to the right hand after lunch and to remove it before dinner. Nursing documentation dated April 4, 2025, at 10:23 PM revealed that Resident 12 removed his hand brace and was chewing it. Nursing documentation dated April 7, 2025, at 11:01 AM revealed that Resident 12 was sucking on his hand splint, and the Velcro was worn out. The documentation indicated that a new physician's order requested a screen by occupational therapy. Occupational therapy screen documentation dated April 7, 2025, noted that Resident 12's right upper extremity hand splint Velcro was not working, and Resident 12 chewed on the splint. The Velcro was	F 0684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395228	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/18/2025
NAME OF PROVIDER OR SUPPLIER: COLE PLACE STATE LICENSE NUMBER: 031802		STREET ADDRESS, CITY, STATE, ZIP CODE: 1001 EAST SECOND STREET COUDERSPORT, PA 16915		
(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 0684 SS=D	Continued from page 16 worn down and dirty with fabric ripping off the splint. The documentation stipulated that, "This splint type/model remains appropriate; however, a new one will need to be ordered due to current one falling apart from wear and tear. Regarding Pt (patient/resident) being found chewing on splint it is recommended to place tubi-grip sock (tubular elastic material that can be cut to size) over splint to increase longevity of splint and decrease Pt attempt at chewing on splint." The documentation indicated a continuation of the established splinting RNP and hand hygiene. Observation of Resident 12 on April 16, 2025, at 9:14 AM during an interview with Employee 3 (nurse aide) revealed that Resident 12 was not wearing a splint to his right hand while he was in bed because staff needed to watch him (in the common activity area on the unit) so he would not eat the splint. Observation of Resident 12 on April 16, 2025, at 2:04 PM revealed he was in his wheelchair in the	F 0684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395228	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/18/2025
NAME OF PROVIDER OR SUPPLIER: COLE PLACE STATE LICENSE NUMBER: 031802		STREET ADDRESS, CITY, STATE, ZIP CODE: 1001 EAST SECOND STREET COUDERSPORT, PA 16915		
(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 0684 SS=D	Continued from page 17 common activity area on the unit without any hand splint on his right hand. Interview with Employee 3 on April 16, 2025, at 2:28 PM confirmed that she did not apply Resident 12's right hand splint after lunch. Employee 3 showed the surveyor the available splint for Resident 12, which had tubular cloth pieces meant to separate the fingers of the hand; however, the foam spacers were missing due to Resident 12 chewing the splint. Employee 3 displayed the ineffective Velcro portion of the splint that prohibited the consistent positioning of the splint. Employee 3 stated that she documented the application of the splint although Resident 12 did not wear the splint during her shift. Observation of Resident 12 on April 16, 2025, at 3:40 PM (following the surveyor's questioning) revealed he was in the common activity area on the unit with a splint on his right hand; however, there was no tubi-grip sock over the device as recommended by the occupational therapy screen.	F 0684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395228	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/18/2025
NAME OF PROVIDER OR SUPPLIER: COLE PLACE STATE LICENSE NUMBER: 031802		STREET ADDRESS, CITY, STATE, ZIP CODE: 1001 EAST SECOND STREET COUDERSPORT, PA 16915		
(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 0684 SS=D	Continued from page 18 There were also no foam spacers separating his fingers. The surveyor reviewed the above concerns regarding Resident 12's right hand splint during an interview with the Nursing Home Administrator and the Director of Nursing on April 17, 2025, at 2:00 PM. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services	F 0684		
F 0791 SS=D		F 0791		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395228	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/18/2025
NAME OF PROVIDER OR SUPPLIER: COLE PLACE STATE LICENSE NUMBER: 031802		STREET ADDRESS, CITY, STATE, ZIP CODE: 1001 EAST SECOND STREET COUDERSPORT, PA 16915		
(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 0791 SS=D	Continued from page 19 483.55(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	The Facility submits this Plan of Correction under procedures established by the Department of Health in order to comply with the Department's directive to change conditions which the Department alleges is deficient under State and/or Federal Long Term Care Regulations. This Plan of Correction should not be construed as either a waiver of the facility's right to appeal or challenge the accuracy or severity of the alleged deficiencies or an admission of past or ongoing violation of State or Federal regulatory requirements. 1. Resident 1 was seen by dentist on 4/22/25. Reviewed dentist recommendations for resident and follow-up as indicated with resident/resident representative, follow-up will be completed as indicated and the plan of care will be updated. 2. A retrospective review of all residents' most recent dental consult	Completion Date: 05/22/2025 Status: APPROVED Date: 05/08/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395228	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/18/2025
NAME OF PROVIDER OR SUPPLIER: COLE PLACE STATE LICENSE NUMBER: 031802		STREET ADDRESS, CITY, STATE, ZIP CODE: 1001 EAST SECOND STREET COUDERSPORT, PA 16915		
(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 0791 SS=D	Continued from page 20 §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	will be completed to ensure recommendations for oral specialists were reviewed with the resident/resident responsible party and scheduled follow-up is coordinated as indicated. 3. The Administrator and/or designee will educate all RNs, LPNs, and Social worker, regarding the need to ensure recommendations for oral specialists were reviewed with the resident/resident responsible party and scheduled follow-up is coordinated as indicated. 4. The Social Worker and/or designee will audit all new dental consult notes to ensure recommendations for oral specialists were reviewed with the resident/resident responsible party and scheduled follow-up is coordinated as indicated. Audits will be completed bi-weekly for 2 months, or until substantial compliance is achieved. Results will be reviewed at the QAPI meeting.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395228	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/18/2025	
NAME OF PROVIDER OR SUPPLIER: COLE PLACE STATE LICENSE NUMBER: 031802		STREET ADDRESS, CITY, STATE, ZIP CODE: 1001 EAST SECOND STREET COUDERSPORT, PA 16915		
(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 0791 SS=D	Continued from page 21 Based on clinical record review, observation, and family and staff interview, it was determined that the facility failed to obtain routine dental services for one of one resident reviewed for dental concerns (Resident 1). Findings include: Family interview with Resident 1's cousin on April 15, 2025, at 2:45 PM revealed that he believed Resident 1's natural teeth were starting to fall out. He did not have knowledge of any professional dental services provided to Resident 1. Observation of Resident 1 on April 16, 2025, at 8:19 AM revealed that she had several natural teeth, some missing teeth, and all visible teeth were discolored. Clinical record review for Resident 1 revealed documentation by the facility's consultant dental provider dated May 28, 2024, that assessed Resident 1 had decay of at least four teeth, a	F 0791		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395228	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/18/2025
NAME OF PROVIDER OR SUPPLIER: COLE PLACE STATE LICENSE NUMBER: 031802		STREET ADDRESS, CITY, STATE, ZIP CODE: 1001 EAST SECOND STREET COUDERSPORT, PA 16915		
(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 0791 SS=D	Continued from page 22 fractured tooth, and "heavy plaque (a sticky film of bacteria that forms on teeth; removed with routine dental cleanings and daily brushing and flossing. If left untreated, it can cause cavities, gum disease and other oral health issues) and calculus (also called tartar, hardened plaque) buildup of lower anterior teeth...teeth have recession (loss of oral gum tissue) and root exposure covered by the calculus, and generalized mobility." The documentation did not indicate any treatment to remove the heavy plaque and calculus buildup (e.g., professional dental hygienist cleaning). Nursing documentation dated September 18, 2024, at 4:52 PM revealed that Resident 1 was seen by the consultant dental provider due to, "infected gums." The physician ordered the administration of the antibiotic, Augmentin, twice a day for seven days for Resident 1. Documentation by the facility's consultant dental provider dated November 27, 2024, assessed Resident 1 had "Very heavy plaque and calculus	F 0791		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395228	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/18/2025
NAME OF PROVIDER OR SUPPLIER: COLE PLACE STATE LICENSE NUMBER: 031802		STREET ADDRESS, CITY, STATE, ZIP CODE: 1001 EAST SECOND STREET COUDERSPORT, PA 16915		
(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 0791 SS=D	Continued from page 23 buildup generalized throughout, but especially heavy calculus on mandibular (lower jaw) teeth... Difficult to thoroughly evaluate all teeth due to buildup present." The documentation continued to note the decay of at least four teeth, a fractured tooth, and noted "Advised patient would need to see OS (oral surgeon) for necessary extractions. Patient has previously refused dental treatment due to no pain and progressing cancer. Advised patient to let us know if she starts to have any pain or swelling in her mouth." Section C, Cognitive Patterns (section intended to determine the resident's attention, orientation, and ability to register and recall new information and whether the resident has signs and symptoms of delirium; these items are crucial factors in many care-planning decisions) of a quarterly MDS (Minimum Data Set, an assessment tool completed at specific intervals to determine resident care needs) assessment dated May 8, 2024, revealed Resident 1 had a BIMS (Brief Interview for Mental Status, a brief screener that aids in detecting	F 0791		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395228	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/18/2025
NAME OF PROVIDER OR SUPPLIER: COLE PLACE STATE LICENSE NUMBER: 031802		STREET ADDRESS, CITY, STATE, ZIP CODE: 1001 EAST SECOND STREET COUDERSPORT, PA 16915		
(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 0791 SS=D	Continued from page 24 cognitive impairment) score of three (a score of zero to seven indicates severe cognitive impairment). The assessment also recorded that she had inattentiveness and disorganized thinking. A quarterly MDS dated November 7, 2024, assessed Resident 1's BIMS score as two. The assessment also recorded that she had inattentiveness and disorganized thinking. An annual MDS dated February 7, 2025, noted that Resident 1 had inflamed or bleeding gums or loose natural teeth but did not note that she had obvious cavities and broken natural teeth (as documented by the facility's contracted dental provider). The consultant dental provider's documentation referred to advising Resident 1 of her need to see an oral surgeon for necessary extractions and that Resident 1 had previously refused dental treatment; however, Resident 1's cognitive status (as recorded in her MDS assessments) prevented her from effectively participating in her care planning	F 0791		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395228	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/18/2025
NAME OF PROVIDER OR SUPPLIER: COLE PLACE STATE LICENSE NUMBER: 031802		STREET ADDRESS, CITY, STATE, ZIP CODE: 1001 EAST SECOND STREET COUDERSPORT, PA 16915		
(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 0791 SS=D	Continued from page 25 decisions. The surveyor reviewed the above concerns regarding Resident 1's professional dental services during an interview with the Nursing Home Administrator and the Director of Nursing on April 17, 2025, at 2:00 PM. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services	F 0791		
F 0880 SS=E		F 0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395228	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/18/2025	
NAME OF PROVIDER OR SUPPLIER: COLE PLACE STATE LICENSE NUMBER: 031802		STREET ADDRESS, CITY, STATE, ZIP CODE: 1001 EAST SECOND STREET COUDERSPORT, PA 16915		
(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 0880 SS=E	Continued from page 26 483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §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. §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: §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; §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;	F 0880	The Facility submits this Plan of Correction under procedures established by the Department of Health in order to comply with the Department's directive to change conditions which the Department alleges is deficient under State and/or Federal Long Term Care Regulations. This Plan of Correction should not be construed as either a waiver of the facility's right to appeal or challenge the accuracy or severity of the alleged deficiencies or an admission of past or ongoing violation of State or Federal regulatory requirements. 1. No individual residents were identified as impacted. At the time of the finding environmental staff was verbally reminded about the importance of keeping laundry in sealed bags and the use of PPE during laundry processing. 2. The Director of Nursing and/or designee will educate all environmental service staff and	Completion Date: 05/22/2025 Status: APPROVED Date: 05/08/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395228	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/18/2025
NAME OF PROVIDER OR SUPPLIER: COLE PLACE STATE LICENSE NUMBER: 031802		STREET ADDRESS, CITY, STATE, ZIP CODE: 1001 EAST SECOND STREET COUDERSPORT, PA 16915		
(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 0880 SS=E	Continued from page 27 (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	nursing assistants on the need to place resident personal laundry that is in a mesh bag in a plastic bag before removing from the residents' room and the importance of using PPE when working in the soiled laundry area to prevent the potential spread of infection related to resident personal laundry processing. 3. The Administrator and/or designee will educate the Director of Nursing and Human Resources on the updates to the facility policy COVID-19 Testing and Exposure Management. Specifically, but not limited to the need to consider the continuum of options for addressing staffing shortages, and that contingency strategies followed by crisis strategies are provided to augment conventional strategies and are meant to be considered and implemented sequentially, as per the CDC, "when staffing shortages are anticipated, healthcare facilities and employers, in collaboration with human resources and occupational	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395228	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/18/2025
NAME OF PROVIDER OR SUPPLIER: COLE PLACE STATE LICENSE NUMBER: 031802		STREET ADDRESS, CITY, STATE, ZIP CODE: 1001 EAST SECOND STREET COUDERSPORT, PA 16915		
(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 0880 SS=E	Continued from page 28	F 0880	<p>health services, should use capacity strategies to plan and prepare for mitigating this problem." Director of Nursing will also be educated on the need to also consider the PA DOH staffing Ratios and Hours Per Patient Day (HPPD) requirements while balancing strategies to mitigate staffing shortages, safe staffing to meet resident needs and providing evidence of measures considered.</p> <p>4. The Director of Nursing and/or designee will conduct 5 visual audits per week for 2 months to ensure the environmental service staff and/or nursing assistants place resident personal laundry that is in a mesh bag in a plastic bag for transport and storage and the importance of using PPE when working in the soiled laundry area to prevent the potential spread of infection related to resident personal laundry processing. The NHA and/or designee will conduct an audit on the return to work for any employee who is off due to COVID -19 and what was considered to support a</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395228	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/18/2025
NAME OF PROVIDER OR SUPPLIER: COLE PLACE STATE LICENSE NUMBER: 031802		STREET ADDRESS, CITY, STATE, ZIP CODE: 1001 EAST SECOND STREET COUDERSPORT, PA 16915		
(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 0880 SS=E	Continued from page 29	F 0880	return to work outside of the conventional strategies to mitigate staffing shortages. The audit will be completed for 2 months or until substantial compliance is achieved. Audit findings will be reviewed at the QAPI meeting.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395228	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/18/2025
NAME OF PROVIDER OR SUPPLIER: COLE PLACE STATE LICENSE NUMBER: 031802		STREET ADDRESS, CITY, STATE, ZIP CODE: 1001 EAST SECOND STREET COUDERSPORT, PA 16915		
(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 0880 SS=E	Continued from page 30 Based on a review of select facility policies and procedures, Centers for Disease Control standards, observation, review of personnel payroll records, and staff interview, it was determined that the facility failed to ensure an environment free from the potential spread of infection related to resident personal laundry processing and COVID-19 work exclusions (Employee 3). Findings include: Observation of the facility's resident personal laundry processing procedure on April 18, 2025, at 9:32 AM with Employee 4 (environmental services manager) and Employee 5 (operations manager) revealed that staff gather resident soiled personal laundry in a mesh bag in the resident's room. Staff transfer the soiled resident laundry from the resident room to a large, open, cart in the nursing unit's soiled utility room in the mesh bag. The mesh bag would not provide leak-resistant protection for staff to prevent the potential	F 0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395228	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/18/2025
NAME OF PROVIDER OR SUPPLIER: COLE PLACE STATE LICENSE NUMBER: 031802		STREET ADDRESS, CITY, STATE, ZIP CODE: 1001 EAST SECOND STREET COUDERSPORT, PA 16915		
(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 0880 SS=E	Continued from page 31 contamination of their clothing from resident bodily substances during transport. Observation of nursing unit's soiled utility room with Employees 4 and 5 on April 18, 2025, at 9:35 AM revealed a large, open, bin where mesh bags of soiled resident laundry are held. There was no lid to the bin. Interview with Employees 4 and 5 on the date and time of the observation revealed that nursing staff are instructed to rinse heavily soiled garments in the soiled utility hopper before placing the items in the open cart. The interview confirmed that there were no isolation gowns in the soiled utility room to protect staff clothing from splashes should staff rinse the potentially infectious clothing in the soiled utility room. The action of rinsing any contaminated laundry in the soiled utility room would result in some agitation that could potentially contaminate the air, surfaces, and persons in the soiled utility room (who would not have eye protection or isolation gowns for protection). The interview indicated that staff from the facility's laundry department don gloves to collect the mesh	F 0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395228	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/18/2025
NAME OF PROVIDER OR SUPPLIER: COLE PLACE STATE LICENSE NUMBER: 031802		STREET ADDRESS, CITY, STATE, ZIP CODE: 1001 EAST SECOND STREET COUDERSPORT, PA 16915		
(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 0880 SS=E	Continued from page 32 bags from the large open bin to transfer them to their large, lidded, bins for transport to the facility's main soiled utility room on another floor. The interview confirmed that laundry staff do not don an isolation gown before transferring the mesh bags; therefore, there is the potential for uncontained infectious material from the soiled laundry to leak through the mesh bags potentially contaminating the staff's clothing during the transferring of the mesh bags from bin to bin. The action of transferring the mesh bags in the soiled utility room would result in some agitation that could potentially contaminate the air, surfaces, and persons in the soiled utility room (who would not have eye protection or isolation gowns for protection). The surveyor reviewed the above concerns regarding the facility's resident personal laundry processing with the Nursing Home Administrator on April 18, 2025, at 10:30 AM. The facility policy entitled, "COVID-19 Testing and Exposure Management," last reviewed on	F 0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395228	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/18/2025
NAME OF PROVIDER OR SUPPLIER: COLE PLACE STATE LICENSE NUMBER: 031802		STREET ADDRESS, CITY, STATE, ZIP CODE: 1001 EAST SECOND STREET COUDERSPORT, PA 16915		
(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 0880 SS=E	Continued from page 33 September 6, 2024, revealed that if COVID-19 is confirmed, staff should follow Centers for Disease Control (CDC) guidance "Interim Guidance for Managing Healthcare Personnel with SARSCoV-2 (COVID-19) Infection or Exposure to SARS-CoV-2." Conventional return-to-work criteria is that, regardless of vaccination status, staff would return in 10 days or in seven days with a negative test, if asymptomatic or with mild to moderate illness (with improving symptoms). Centers for Disease Control criteria for staff to return to work following COVID-19 infection (https://www.cdc.gov/covid/hcp/infection-control/guidance-risk-assesment-hcp.html?CDC_AAref_Val=https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assesment-hcp.html) revealed that health care personnel (HCP) with mild to moderate illness who are not moderately to severely immunocompromised could return to work after the following criteria have been met: At least seven days have passed since symptoms	F 0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395228	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/18/2025	
NAME OF PROVIDER OR SUPPLIER: COLE PLACE STATE LICENSE NUMBER: 031802		STREET ADDRESS, CITY, STATE, ZIP CODE: 1001 EAST SECOND STREET COUDERSPORT, PA 16915		
(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 0880 SS=E	Continued from page 34 first appeared if a negative viral test is obtained within 48 hours prior to returning to work (or 10 days if testing is not performed or if a positive test at day 5-7), and At least 24 hours have passed since last fever without the use of fever-reducing medications, and Symptoms (e.g., cough, shortness of breath) have improved. (If using an antigen test (can give results in as little as 15 minutes, do not require laboratory testing for the results), HCP should have a negative test obtained on day 5 and again 48 hours later) CDC permits earlier return to work parameters in situations where contingency or crisis staffing criteria are met (https://www.cdc.gov/covid/hcp/infection-control/mitigating-staff-shortages.html). CDC's mitigation strategies offer a continuum of options for addressing staffing shortages. Contingency strategies followed by crisis strategies are provided to augment conventional strategies and are meant to be considered and implemented sequentially (i.e.,	F 0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395228	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/18/2025	
NAME OF PROVIDER OR SUPPLIER: COLE PLACE STATE LICENSE NUMBER: 031802		STREET ADDRESS, CITY, STATE, ZIP CODE: 1001 EAST SECOND STREET COUDERSPORT, PA 16915		
(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 0880 SS=E	Continued from page 35 implementing conventional strategies followed by contingency strategies followed by crisis strategies). The guidance is for healthcare facilities that are expecting or experiencing staffing shortages due to COVID-19. For example, if, despite efforts to mitigate, HCP staffing shortages occur, facilities might determine that, to ensure the availability of healthcare, certain HCP with suspected or confirmed COVID-19 infection should return to work before the full conventional Return to Work Criteria have been met. Healthcare facilities (in collaboration with risk management) would inform residents and HCP when the facility was utilizing these strategies, specify the changes in practice that should be expected, and describe the actions that would be taken to protect residents and HCP from exposure to COVID-19 if HCP with suspected or confirmed COVID-19 infection are requested to work to fulfill staffing needs. These would include: Understand the local epidemiology of COVID-19-related indicators (e.g., community transmission levels).	F 0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395228	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/18/2025	
NAME OF PROVIDER OR SUPPLIER: COLE PLACE STATE LICENSE NUMBER: 031802		STREET ADDRESS, CITY, STATE, ZIP CODE: 1001 EAST SECOND STREET COUDERSPORT, PA 16915		
(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 0880 SS=E	Continued from page 36 Communicate with local healthcare coalitions and federal, state, and local public health partners to identify additional HCP (e.g., hiring additional HCP, recruiting retired HCP, using students or volunteers), when needed. Adjusting staff schedules, hiring additional HCP, and rotating HCP to positions that support patient care activities. Cancel all non-essential procedures and visits. Shift HCP who work in these areas to support other patient care activities in the facility. Attempt to address social factors that might prevent HCP from reporting to work, such as need for transportation or housing that allows for physical distancing. Identify additional HCP to work in the facility. As appropriate, request that HCP postpone elective time off from work. Developing regional plans to identify designated healthcare facilities or alternate care sites with adequate staffing to care for patients with SARS-CoV-2 infection.	F 0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395228	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/18/2025
NAME OF PROVIDER OR SUPPLIER: COLE PLACE STATE LICENSE NUMBER: 031802		STREET ADDRESS, CITY, STATE, ZIP CODE: 1001 EAST SECOND STREET COUDERSPORT, PA 16915		
(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 0880 SS=E	Continued from page 37 Interview with Employee 3 (nurse aide) on April 16, 2025, at 2:30 PM revealed that she tested positive for COVID-19 twice in the past year. Employee 3 stated that she returned to work approximately five days after her positive test on each occasion but that she had no COVID-19 testing after her initial positive result. Employee 3 stated that she decided to test for COVID-19 because she had symptoms of the common cold each time she tested positive. Review of the facility's submissions to the Department of Health Event Reporting System (ERS, online system established for facilities to comply with required notification to the Department of the facility's reportable events) revealed that Employee 3 tested positive for COVID-19 on November 4, 2024, (ERS report 1047840, day zero). Review of Employee 3's timecard revealed that she worked November 9, 10, 11, 13, and 14 2024, (days 5 through 10) after her positive result.	F 0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395228	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/18/2025	
NAME OF PROVIDER OR SUPPLIER: COLE PLACE STATE LICENSE NUMBER: 031802		STREET ADDRESS, CITY, STATE, ZIP CODE: 1001 EAST SECOND STREET COUDERSPORT, PA 16915		
(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 0880 SS=E	<p>Continued from page 38</p> <p>Review of the facility's ERS submissions to the Department revealed that Employee 3 tested positive for COVID-19 on January 2, 2025, (ERS report 1060917).</p> <p>Review of Employee 3's timecard revealed that she worked January 8, 9, and 10, 2025c, (days 6, 7, and 8) after her positive result.</p> <p>The surveyor requested any evidence of COVID-19 testing for Employee 3 dated November 2024, through January 2025, during interviews with the Nursing Home Administrator and the Director of Nursing on April 16, 2025, at 1:00 PM and April 17, 2025, at 2:00 PM; however, the facility did not provide any results during the onsite survey.</p> <p>Interview with the Nursing Home Administrator and the Director of Nursing on April 17, 2025, at 2:00 PM confirmed that the facility had no evidence of additional cases of COVID-19 (besides Employee 3 to support staffing shortages due to COVID-19),</p>	F 0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395228	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/18/2025
NAME OF PROVIDER OR SUPPLIER: COLE PLACE STATE LICENSE NUMBER: 031802		STREET ADDRESS, CITY, STATE, ZIP CODE: 1001 EAST SECOND STREET COUDERSPORT, PA 16915		
(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 0880 SS=E	Continued from page 39 had not progressed through any measures between conventional nurse staffing to contingent nurse staffing, nor had any communications with local healthcare coalitions and federal, state, and local public health partners to identify additional HCP that were needed in a contingency staffing situation. The facility had no evidence of measures implemented as an effort to mitigate staffing shortages before implementing CDC's contingency staffing allowances for staff's return to work. The facility permitted Employee 3 to return to work after COVID-19 infection on November 9, 2024 (day 5) and January 8, 2025 (day 6) without any negative COVID-19 testing results, which was outside CDC's conventional strategy parameters. 483.80(a)(1)(2)(4)(e)(f) Infection Prevention and Control Previously cited deficiency 5/10/24 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services	F 0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395228	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/18/2025
--	---	---	--

NAME OF PROVIDER OR SUPPLIER: COLE PLACE STATE LICENSE NUMBER: 031802	STREET ADDRESS, CITY, STATE, ZIP CODE: 1001 EAST SECOND STREET COUDERSPORT, PA 16915
---	--

(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 0883 SS=E		F 0883		
--------------------	--	--------	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395228	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/18/2025
NAME OF PROVIDER OR SUPPLIER: COLE PLACE STATE LICENSE NUMBER: 031802		STREET ADDRESS, CITY, STATE, ZIP CODE: 1001 EAST SECOND STREET COUDERSPORT, PA 16915		
(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 0883 SS=E	Continued from page 41 483.80(d)(1)(2) Influenza and Pneumococcal Immunizations §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization;	F 0883	The Facility submits this Plan of Correction under procedures established by the Department of Health in order to comply with the Department's directive to change conditions which the Department alleges is deficient under State and/or Federal Long Term Care Regulations. This Plan of Correction should not be construed as either a waiver of the facility's right to appeal or challenge the accuracy or severity of the alleged deficiencies or an admission of past or ongoing violation of State or Federal regulatory requirements. 1. The Pneumococcal immunization status for residents 2, 7, 10, 12, and 14 was reviewed. The influenza immunization status of resident 10 was reviewed. Residents' and/or resident representatives' 2, 7, 10,12 and 14 were provided education regarding the benefits and potential side effects of the pneumonia vaccine. Resident/Responsible party 10 was provided education regarding the potential risks and	Completion Date: 05/22/2025 Status: APPROVED Date: 05/08/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395228	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/18/2025
NAME OF PROVIDER OR SUPPLIER: COLE PLACE STATE LICENSE NUMBER: 031802		STREET ADDRESS, CITY, STATE, ZIP CODE: 1001 EAST SECOND STREET COUDERSPORT, PA 16915		
(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 0883 SS=E	Continued from page 42 (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by:	F 0883	benefits of the influenza vaccine and declination revisited. The clinical record has been updated to reflect the administration of the pneumococcal vaccine as indicated for residents 2,7,10,12, and 14. 2. All current residents' pneumococcal and influenza immunization statuses will be reviewed. Residents/Resident representatives will be provided education on the potential risks and benefits of the pneumococcal and influenza vaccine. Residents/resident representatives will be offered the pneumococcal and influenza vaccines as indicated and the clinical record will be updated to reflect the administration of pneumococcal and influenza vaccines. 3. The pneumococcal and influenza immunization statuses will be reviewed for all new admissions. Residents/resident representatives will be provided education on the potential risks and benefits of the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395228	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/18/2025
NAME OF PROVIDER OR SUPPLIER: COLE PLACE STATE LICENSE NUMBER: 031802		STREET ADDRESS, CITY, STATE, ZIP CODE: 1001 EAST SECOND STREET COUDERSPORT, PA 16915		
(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 0883 SS=E	Continued from page 43	F 0883	<p>pneumococcal and influenza vaccines as part of the admission packet. Residents/residents representatives will be offered the pneumococcal and influenza vaccines as indicated and the clinical record will be updated to reflect the administration of pneumococcal and influenza vaccines. The Administrator will educate RNs, LPNs, and social worker on this system alteration.</p> <p>4. The Director of Nursing and/or designee will audit the pneumococcal and influenza immunization clinical documentation for all new admissions for 3 months or until substantial compliance is achieved to ensure Residents/Resident representatives were provided education on the potential risks and benefits of the pneumococcal and influenza vaccines, to ensure Residents/residents representatives were offered the pneumococcal and influenza vaccines as indicated and that the clinical record was updated</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395228	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____		(X3) DATE SURVEY COMPLETED: 04/18/2025
NAME OF PROVIDER OR SUPPLIER: COLE PLACE STATE LICENSE NUMBER: 031802			STREET ADDRESS, CITY, STATE, ZIP CODE: 1001 EAST SECOND STREET COUDERSPORT, PA 16915		
(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 0883 SS=E	Continued from page 44	F 0883	to reflect the administration of pneumococcal and influenza vaccines. Results will be reviewed at the QAPI meeting.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395228	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/18/2025
NAME OF PROVIDER OR SUPPLIER: COLE PLACE STATE LICENSE NUMBER: 031802		STREET ADDRESS, CITY, STATE, ZIP CODE: 1001 EAST SECOND STREET COUDERSPORT, PA 16915		
(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 0883 SS=E	Continued from page 45 Based on a review of select facility policies and procedures, current Centers for Disease Control (CDC) guidelines, clinical record review, and staff interview, it was determined that the facility failed to document each resident was offered an influenza and pneumococcal immunization, the resident or resident's representative was provided education regarding the benefits and potential side effects of immunizations, and that each resident either received immunization or did not receive immunization for five of five residents reviewed for influenza and pneumococcal immunization concerns (Residents 2, 7, 10, 12, and 14). Findings include: The facility policy entitled, "Vaccination Including Influenza, Pneumococcal, and COVID-19 Immunizations," last reviewed September 5, 2024, revealed that when the influenza and pneumococcal vaccines are available at the facility, each resident is offered the vaccine unless the immunization is medically contraindicated, or the resident has	F 0883		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395228	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/18/2025
NAME OF PROVIDER OR SUPPLIER: COLE PLACE STATE LICENSE NUMBER: 031802		STREET ADDRESS, CITY, STATE, ZIP CODE: 1001 EAST SECOND STREET COUDERSPORT, PA 16915		
(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 0883 SS=E	Continued from page 46 already been immunized. Before offering the influenza or pneumococcal vaccine, each resident or the resident representative receives education regarding the benefits and risks and potential side effects associated with the vaccine. The resident's medical record includes documentation that indicates at a minimum the following: That the resident or resident representative was provided education regarding the benefits and potential risks associated with the influenza or pneumococcal vaccine; and Each dose of influenza or pneumococcal vaccine administered to the resident; or If the resident did not receive the influenza or pneumococcal vaccine due to medical contraindication or refusal Clinical record review of Resident 2's immunization record revealed no history of the administration of a pneumococcal vaccine. Resident 2's clinical record contained no evidence that Resident 2 and/or his responsible party was provided education regarding	F 0883		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395228	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/18/2025
NAME OF PROVIDER OR SUPPLIER: COLE PLACE STATE LICENSE NUMBER: 031802		STREET ADDRESS, CITY, STATE, ZIP CODE: 1001 EAST SECOND STREET COUDERSPORT, PA 16915		
(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 0883 SS=E	Continued from page 47 the potential risks and benefits of the pneumococcal vaccine. Current CDC guidelines stipulate that based on shared clinical decision-making (between a physician and a resident/responsible party), adults 65 years or older have the option to get a PCV20 or PCV21 vaccine if they have received both a PCV13 (but not PCV15, PCV20, or PCV21) at any age and PPSV23 at or after the age of 65 years old. Clinical record review for Resident 7 revealed that she received a PPSV23 vaccine on September 24, 2001, (when she was 72 years old) and a PCV13 vaccine on September 17, 2016, (when she was 87 years old). Resident 7's clinical record contained no evidence that the facility ensured Resident 7 or Resident 7's responsible party received education regarding the risks and benefits of the PCV20 or PCV21 immunizations or decided with Resident 7's	F 0883		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395228	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/18/2025	
NAME OF PROVIDER OR SUPPLIER: COLE PLACE STATE LICENSE NUMBER: 031802		STREET ADDRESS, CITY, STATE, ZIP CODE: 1001 EAST SECOND STREET COUDERSPORT, PA 16915		
(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 0883 SS=E	Continued from page 48 physician to receive or refuse the PCV20 or PCV21 immunization per current CDC guidelines. Clinical record review for Resident 10 revealed an Acknowledgement of Admission Handbook Consent Checklist where Resident 10's responsible party declined consent to a yearly influenza and pneumonia immunization. The document did not include evidence of the provision of education regarding benefits and potential side effects of the influenza or pneumococcal immunizations. Review of Resident 10's immunization record did not include any reference to a pneumococcal or influenza immunization (either received or refused). Clinical record review of Resident 12's immunization record revealed no history of the administration of a pneumococcal vaccine. Resident 12's clinical record contained no evidence that Resident 12 and/or his responsible party was provided education regarding the potential risks and benefits of the pneumococcal vaccine.	F 0883		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395228	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/18/2025
NAME OF PROVIDER OR SUPPLIER: COLE PLACE STATE LICENSE NUMBER: 031802		STREET ADDRESS, CITY, STATE, ZIP CODE: 1001 EAST SECOND STREET COUDERSPORT, PA 16915		
(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 0883 SS=E	Continued from page 49 Clinical record review of Resident 14's immunization record revealed no history of the administration of a pneumococcal vaccine. Resident 14's clinical record contained no evidence that Resident 14 and/or his responsible party was provided education regarding the potential risks and benefits of the pneumococcal vaccine. The surveyor reviewed the above concerns regarding the pneumococcal and influenza immunization status for Residents 2, 7, 10, 12, and 14 during an interview with the Nursing Home Administrator and the Director of Nursing on April 17, 2025, at 2:00 PM. 28 Pa. Code 211.5(f)(i)-(xi) Medical records 28 Pa. Code 211.12(d)(1)(5) Nursing services	F 0883		
F 0887 SS=E		F 0887		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395228	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/18/2025
NAME OF PROVIDER OR SUPPLIER: COLE PLACE STATE LICENSE NUMBER: 031802		STREET ADDRESS, CITY, STATE, ZIP CODE: 1001 EAST SECOND STREET COUDERSPORT, PA 16915		
(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 0887 SS=E	Continued from page 50 483.80(d)(3)(i)-(vii) COVID-19 Immunization §483.80(d) (3) COVID-19 immunizations. The LTC facility must develop and implement policies and procedures to ensure all the following: (i) When COVID-19 vaccine is available to the facility, each resident and staff member is offered the COVID-19 vaccine unless the immunization is medically contraindicated or the resident or staff member has already been immunized; (ii) Before offering COVID-19 vaccine, all staff members are provided with education regarding the benefits and risks and potential side effects associated with the vaccine; (iii) Before offering COVID-19 vaccine, each resident or the resident representative receives education regarding the benefits and risks and potential side effects associated with the COVID-19 vaccine; (iv) In situations where COVID-19 vaccination requires multiple doses, the resident, resident representative, or staff member is provided with current information regarding those additional doses, including any changes in the benefits or risks and potential side effects associated with the COVID-19 vaccine, before requesting consent for administration of any additional doses; (v) The resident, resident representative, or staff member has the opportunity to accept or refuse a COVID-19 vaccine, and change their decision;	F 0887	The Facility submits this Plan of Correction under procedures established by the Department of Health in order to comply with the Department's directive to change conditions which the Department alleges is deficient under State and/or Federal Long Term Care Regulations. This Plan of Correction should not be construed as either a waiver of the facility's right to appeal or challenge the accuracy or severity of the alleged deficiencies or an admission of past or ongoing violation of State or Federal regulatory requirements. 1. Residents 2, 7, and 10 were provided with education on the benefits and risk associated to the covid vaccine and offered vaccine if desired. The clinical record has been updated to reflect the administration of the COVID vaccine as indicated for residents 2,7, and10. Employee 3 was provided education on the benefits and risks associated with the and risks and benefits of covid vaccination and where she can get	Completion Date: 05/22/2025 Status: APPROVED Date: 05/08/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395228	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/18/2025
--	---	---	--

NAME OF PROVIDER OR SUPPLIER: COLE PLACE STATE LICENSE NUMBER: 031802	STREET ADDRESS, CITY, STATE, ZIP CODE: 1001 EAST SECOND STREET COUDERSPORT, PA 16915
---	--

(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 0887 SS=E	Continued from page 51 (vi) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident representative was provided education regarding the benefits and potential risks associated with COVID-19 vaccine; and (B) Each dose of COVID-19 vaccine administered to the resident; or (C) If the resident did not receive the COVID-19 vaccine due to medical contraindications or refusal; and (vii) The facility maintains documentation related to staff COVID-19 vaccination that includes at a minimum, the following: (A) That staff were provided education regarding the benefits and potential risks associated with COVID-19 vaccine; (B) Staff were offered the COVID-19 vaccine or information on obtaining COVID-19 vaccine; and (C) The COVID-19 vaccine status of staff and related information as indicated by the Centers for Disease Control and Prevention's National Healthcare Safety Network (NHSN). This REQUIREMENT is not met as evidenced by:	F 0887	the vaccination if desired. 2. All residents' covid vaccine statuses for the 2024-2025 vaccine will be reviewed and vaccine offered with education on risks and benefits. All current employee files reviewed for vaccine education acknowledgement. 3. Covid vaccine review with new residents incorporated into admission process including education on risks and benefits. Covid vaccine education given to new staff upon hire with acknowledgement form. 4. DON or designee will complete audits for new resident covid vaccination education and offer and new hires for covid vaccine education weekly x4 then monthly x2 with results reported to QAPI.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395228	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/18/2025
NAME OF PROVIDER OR SUPPLIER: COLE PLACE STATE LICENSE NUMBER: 031802		STREET ADDRESS, CITY, STATE, ZIP CODE: 1001 EAST SECOND STREET COUDERSPORT, PA 16915		
(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 0887 SS=E	Continued from page 52 Based on a review of select facility policies and procedures, clinical record review, and staff interview, it was determined that the facility failed to ensure each resident is offered the COVID-19 vaccine (including the opportunity to change their decision), that each resident/responsible party receives education regarding the benefits and risks associated with the vaccine, and that the resident's medical record includes documentation of the education provided and that the vaccine was either administered or refused for three of five residents reviewed for immunization concerns (Residents 2, 7, and 10). The facility also failed to maintain COVID-19 vaccine status of staff and related information as indicated by the Centers for Disease Control and Prevention's National Healthcare Safety Network for one of one staff reviewed (Employee 3). Findings include: The facility policy entitled, "Vaccination Including Influenza, Pneumococcal, and COVID-19	F 0887		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395228	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/18/2025	
NAME OF PROVIDER OR SUPPLIER: COLE PLACE STATE LICENSE NUMBER: 031802		STREET ADDRESS, CITY, STATE, ZIP CODE: 1001 EAST SECOND STREET COUDERSPORT, PA 16915		
(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 0887 SS=E	Continued from page 53 Immunizations," last reviewed September 5, 2024, revealed that when the COVID-19 vaccine is available at the facility, each resident and staff member is offered the vaccine unless the immunization is medically contraindicated, or the resident or staff member has already been immunized. Before offering the COVID-19 vaccine, each resident or the resident representative receives education regarding the benefits and risks and potential side effects associated with the vaccine. The resident, resident representative, or staff member can accept or refuse a COVID-19 vaccine and change their decision. The resident's medical record includes documentation that indicates at a minimum the following: That the resident or resident representative was provided education regarding the benefits and potential risks associated with the COVID-19; and Each dose of the COVID-19 vaccine administered to the resident; or If the resident did not receive the COVID-19 vaccine due to medical contraindication or refusal	F 0887		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395228	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/18/2025	
NAME OF PROVIDER OR SUPPLIER: COLE PLACE STATE LICENSE NUMBER: 031802		STREET ADDRESS, CITY, STATE, ZIP CODE: 1001 EAST SECOND STREET COUDERSPORT, PA 16915		
(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 0887 SS=E	Continued from page 54 The facility maintains documentation related to staff COVID-19 vaccination that includes at a minimum the following: That staff were provided education regarding the benefits and potential risks associated with the COVID-19 vaccine. Staff were offered the COVID-19 vaccine or information on obtaining the COVID-19 vaccine; and COVID-19 vaccine status of staff (i.e., immunized or not) and related information as indicated by NHSN (Skilled Nursing Facilities only) The COVID-19 vaccine status of residents and staff, including total numbers of residents and staff, numbers of residents and staff vaccinated, numbers of each dose of COVID-19 vaccine received, and COVID-19 vaccination adverse events Clinical record review for Resident 2 revealed a 2024/2025 COVID-19 Vaccine Consent form signed by Resident 2's responsible party on November 14, 2024, that agreed to the administration of the 2024/2025 COVID-19	F 0887		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395228	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/18/2025
NAME OF PROVIDER OR SUPPLIER: COLE PLACE STATE LICENSE NUMBER: 031802		STREET ADDRESS, CITY, STATE, ZIP CODE: 1001 EAST SECOND STREET COUDERSPORT, PA 16915		
(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 0887 SS=E	Continued from page 55 vaccine. Review of Resident 2's immunization record revealed the facility administered his last COVID-19 vaccine on December 7, 2023. There was no evidence that Resident 2 received the 2024/2025 COVID-19 immunization. Clinical record review of Resident 7's immunization record revealed that the facility documented that she refused a COVID-19 vaccine on March 22, 2021, (four years earlier). There was no evidence in Resident 7's medical record that the facility afforded her the opportunity to change her decision to receive the COVID-19 vaccine since 2021 or offered her education regarding the risks and benefits of the COVID-19 2024/2025 immunization. Clinical record review of Resident 10's immunization record revealed no evidence that she received or refused the COVID-19 immunization. Resident	F 0887		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395228	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/18/2025	
NAME OF PROVIDER OR SUPPLIER: COLE PLACE STATE LICENSE NUMBER: 031802	STREET ADDRESS, CITY, STATE, ZIP CODE: 1001 EAST SECOND STREET COUDERSPORT, PA 16915			
(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 0887 SS=E	Continued from page 56 10's clinical record contained no evidence of education provided regarding the benefits and potential risks of the vaccine. The surveyor reviewed the above concerns regarding the COVID-19 immunization status for Residents 2, 7, and 10, during an interview with the Nursing Home Administrator and the Director of Nursing on April 17, 2025, at 2:00 PM. The surveyor requested information regarding Employee 3's (nurse aide) COVID-19 immunization status during an interview with the Director of Nursing and the Nursing Home Administrator on April 16, 2025, at 1:00 PM and April 17, 2025, at 2:00 PM. The facility did not provide any information regarding Employee 3's COVID-19 vaccination status during the onsite survey. 28 Pa. Code 211.5(f)(i)-(xi) Medical records 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services	F 0887		

Pennsylvania Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395228	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/18/2025
--	---	---	--

NAME OF PROVIDER OR SUPPLIER: COLE PLACE STATE LICENSE NUMBER: 031802	STREET ADDRESS, CITY, STATE, ZIP CODE: 1001 EAST SECOND STREET COUDERSPORT, PA 16915
---	--

(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 1020		P 1020		

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: 395228	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/18/2025
NAME OF PROVIDER OR SUPPLIER: COLE PLACE STATE LICENSE NUMBER: 031802		STREET ADDRESS, CITY, STATE, ZIP CODE: 1001 EAST SECOND STREET COUDERSPORT, PA 16915		
(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 1020	Continued from page 1 Responsibility of licensee. (a) The licensee is responsible for meeting the minimum standards for the operation of a facility as set forth by the Department and by other Federal, State and local agencies responsible for the health and welfare of residents. This includes complying with all applicable Federal and State laws, and rules, regulations and orders issued by the Department and other Federal, State or local agencies. This REGULATION is not met as evidenced by:	P 1020	The Facility submits this Plan of Correction under procedures established by the Department of Health in order to comply with the Department's directive to change conditions which the Department alleges is deficient under State and/or Federal Long Term Care Regulations. This Plan of Correction should not be construed as either a waiver of the facility's right to appeal or challenge the accuracy or severity of the alleged deficiencies or an admission of past or ongoing violation of State or Federal regulatory requirements. 1. No individual resident was identified as impacted. 2. A multidisciplinary committee is being assembled that meets the requirements of Act 52, and a meeting will be scheduled to be held at least quarterly. 3. The Regional Director of Operations will educate the current NHA on the need to assemble a	Completion Date: 05/22/2025 Status: APPROVED Date: 05/08/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395228	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/18/2025
NAME OF PROVIDER OR SUPPLIER: COLE PLACE STATE LICENSE NUMBER: 031802		STREET ADDRESS, CITY, STATE, ZIP CODE: 1001 EAST SECOND STREET COUDERSPORT, PA 16915		
(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 1020	Continued from page 2	P 1020	<p>multidisciplinary committee that meets the requirements of Act 52, and that a meeting is to be scheduled and held on a quarterly basis.</p> <p>4. The Regional Director of Operations will audit to ensure that a multidisciplinary committee that meets the requirements of Act 52 is in place, and that a meeting was scheduled and held on a quarterly basis. Audit findings will be reviewed at the QAPI meeting.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395228	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/18/2025
NAME OF PROVIDER OR SUPPLIER: COLE PLACE STATE LICENSE NUMBER: 031802		STREET ADDRESS, CITY, STATE, ZIP CODE: 1001 EAST SECOND STREET COUDERSPORT, PA 16915		
(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 1020	Continued from page 3 Based on staff interview and review of facility documentation, it was determined that the facility did not comply with the multidisciplinary committee requirements of the Act 52 Infection Control Plan. Findings include: Act 52 Infection Control Plan, states that a health care facility should develop and implement an internal infection control plan that should be established for the purpose of improving the health and safety of residents and health care workers and should include a multidisciplinary committee including a representative from each of the following, if applicable to the specific health care facility: (i) Medical staff that could include the chief medical officer or the nursing home medical director (ii) Administration representatives that could include the chief executive officer, the chief financial officer, or the nursing home administrator (iii) Laboratory personnel (iv) Nursing staff that could include a director of	P 1020		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395228	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/18/2025
NAME OF PROVIDER OR SUPPLIER: COLE PLACE STATE LICENSE NUMBER: 031802		STREET ADDRESS, CITY, STATE, ZIP CODE: 1001 EAST SECOND STREET COUDERSPORT, PA 16915		
(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 1020	Continued from page 4 nursing or a nursing supervisor (v) Pharmacy staff that could include the chief of pharmacy (vi) Physical plant personnel (vii) A patient safety officer (viii) Members from the infection control team, which could include an epidemiologist. (ix) The community, except that these representatives may not be an agent, employee, or contractor of the health care facility. The surveyor requested infection control committee meeting attendance since the facility's last standard survey (that ended May 10, 2024) during an interview with the Nursing Home Administrator and the Director of Nursing (also the facility's infection preventionist) on April 16, 2025, at 1:00 PM. The surveyor made repeated requests for evidence of the facility's infection control committee meetings and attendance during interviews with the Director of Nursing on April 18, 2025, at 9:00 AM and 10:09 AM. An interview with the Director of	P 1020		

Pennsylvania Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395228	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/18/2025
NAME OF PROVIDER OR SUPPLIER: COLE PLACE STATE LICENSE NUMBER: 031802		STREET ADDRESS, CITY, STATE, ZIP CODE: 1001 EAST SECOND STREET COUDERSPORT, PA 16915		
(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 1020	Continued from page 5 Nursing on April 18, 2025, at 10:09 AM revealed that the facility had no evidence of infection control committee meetings after February 2024.	P 1020		
P 1210		P 1210		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395228	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/18/2025	
NAME OF PROVIDER OR SUPPLIER: COLE PLACE STATE LICENSE NUMBER: 031802		STREET ADDRESS, CITY, STATE, ZIP CODE: 1001 EAST SECOND STREET COUDERSPORT, PA 16915		
(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 1210	Continued from page 6 Management. (2) Protection of personal and property rights of the residents, while in the facility, and upon discharge or after death, including the return of any personal property remaining at the facility within 30 days after discharge or death. This REGULATION is not met as evidenced by:	P 1210	The Facility submits this Plan of Correction under procedures established by the Department of Health in order to comply with the Department's directive to change conditions which the Department alleges is deficient under State and/or Federal Long Term Care Regulations. This Plan of Correction should not be construed as either a waiver of the facility's right to appeal or challenge the accuracy or severity of the alleged deficiencies or an admission of past or ongoing violation of State or Federal regulatory requirements. 1. Resident 16 personal belonging inventory disposition was completed and reviewed with the resident's representative. 2. A retrospective review of the last 3 months of discharges was reviewed for the presence of a personal belonging inventory disposition and completed as indicated.	Completion Date: 05/22/2025 Status: APPROVED Date: 05/08/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395228	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/18/2025
NAME OF PROVIDER OR SUPPLIER: COLE PLACE STATE LICENSE NUMBER: 031802		STREET ADDRESS, CITY, STATE, ZIP CODE: 1001 EAST SECOND STREET COUDERSPORT, PA 16915		
(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 1210	Continued from page 7	P 1210	<p>3. The Director of Nursing and/or designee will educate RNs, LPNs, and Housekeeping to ensure that the personal belongings inventory disposition is completed and reviewed with the resident/resident representative as indicated.</p> <p>4. The Director of Nursing and/or designee will audit all closed records to ensure that the personal belongings inventory disposition is completed and reviewed with the resident/resident representative as indicated. The audit will be completed for 3 months or until substantial compliance is achieved. Results will be reviewed at the quarterly QA meeting.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395228	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/18/2025
NAME OF PROVIDER OR SUPPLIER: COLE PLACE STATE LICENSE NUMBER: 031802		STREET ADDRESS, CITY, STATE, ZIP CODE: 1001 EAST SECOND STREET COUDERSPORT, PA 16915		
(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 1210	Continued from page 8 Based on closed clinical record review and staff interview, it was determined that there was no evidence that identified the disposition of a resident's personal belongings following discharge from the facility for one of two closed records reviewed (Resident 16). Findings include: Closed clinical record review revealed the facility admitted Resident 16 on February 8, 2025. Further review of Resident 16's clinical record revealed she passed away on March 5, 2025. A review of Resident 16's personal belongings inventory form revealed items such as prescription glasses, clothes, shoes, cell phone, cell phone charger, and other miscellaneous items. Further review of Resident 16's closed clinical record revealed no documentation to indicate the disposition of Resident 16's personal belongings. Interview with the Nursing Home Administrator and	P 1210		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395228	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/18/2025
NAME OF PROVIDER OR SUPPLIER: COLE PLACE STATE LICENSE NUMBER: 031802		STREET ADDRESS, CITY, STATE, ZIP CODE: 1001 EAST SECOND STREET COUDERSPORT, PA 16915		
(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 1210	Continued from page 9 Director of Nursing on April 18, 2025, at 2:00 PM confirmed the above noted findings related to the disposition of Resident 16's personal belongings.	P 1210		
P 5520		P 5520		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395228	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/18/2025	
NAME OF PROVIDER OR SUPPLIER: COLE PLACE STATE LICENSE NUMBER: 031802		STREET ADDRESS, CITY, STATE, ZIP CODE: 1001 EAST SECOND STREET COUDERSPORT, PA 16915		
(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 10 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	The Facility submits this Plan of Correction under procedures established by the Department of Health in order to comply with the Department's directive to change conditions which the Department alleges is deficient under State and/or Federal Long Term Care Regulations. This Plan of Correction should not be construed as either a waiver of the facility's right to appeal or challenge the accuracy or severity of the alleged deficiencies or an admission of past or ongoing violation of State or Federal regulatory requirements. 1. At the time of the finding, the ratios and total nursing hours for the current working schedule were reviewed and staffing was sufficient to meet the needs of the residents or there was sufficient time to coordinate sufficient staffing. 2. The RNs and LPNs will be re-educated on the nursing assistant ratio requirements, and the importance of monitoring staffing as	Completion Date: 05/22/2025 Status: APPROVED Date: 05/08/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395228	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/18/2025
NAME OF PROVIDER OR SUPPLIER: COLE PLACE STATE LICENSE NUMBER: 031802		STREET ADDRESS, CITY, STATE, ZIP CODE: 1001 EAST SECOND STREET COUDERSPORT, PA 16915		
(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 11	P 5520	<p>the day and/or shift progress. Education will be completed by the Director of Nursing and/or designee.</p> <p>3. The Director of Nursing and/or designee will audit the current working schedule, and the deployment sheets prior to the day and after the day is complete to ensure nursing assistant ratios have been met.</p> <p>4. Audits will be completed 3 times per week for 1 month, and weekly for 1 month thereafter or until substantial compliance is achieved. Results will be reviewed at the QAPI meeting.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395228	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/18/2025
NAME OF PROVIDER OR SUPPLIER: COLE PLACE STATE LICENSE NUMBER: 031802		STREET ADDRESS, CITY, STATE, ZIP CODE: 1001 EAST SECOND STREET COUDERSPORT, PA 16915		
(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 12 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 (NA) per 15 residents during the overnight shift for five of the 21 days reviewed. Findings include: Review of nursing staff care hours provided by the facility for December 28, 2024, through January 3, 2025, February 8 to 14, 2025, and April 10 to 16, 2025, revealed the following NAs scheduled for the resident census: Night shift (requires one NA per 15 residents): February 9, 2025, census of 18 with 1.00 NAs, required 1.20 NAs February 11, 2025, census of 20 with 1.00 NAs, required 1.33 NAs April 11, 2025, census of 17 with 1.00 NAs, required 1.13 NAs April 12, 2025, census of 17 with 1.00 NAs,	P 5520		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395228	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/18/2025
NAME OF PROVIDER OR SUPPLIER: COLE PLACE STATE LICENSE NUMBER: 031802		STREET ADDRESS, CITY, STATE, ZIP CODE: 1001 EAST SECOND STREET COUDERSPORT, PA 16915		
(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 13 required 1.13 NAs April 13, 2025, census of 17 with 1.00 NAs, required 1.13 NAs Interview with the Nursing Home Administrator and Director of Nursing on April 16, 2025, at 1:00 PM confirmed that the facility did not meet regulatory NA-to- resident ratios as evidenced above.	P 5520		
P 5530		P 5530		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395228	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/18/2025
NAME OF PROVIDER OR SUPPLIER: COLE PLACE STATE LICENSE NUMBER: 031802		STREET ADDRESS, CITY, STATE, ZIP CODE: 1001 EAST SECOND STREET COUDERSPORT, PA 16915		
(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 5530	Continued from page 14 Nursing services. (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. This REGULATION is not met as evidenced by:	P 5530	The Facility submits this Plan of Correction under procedures established by the Department of Health in order to comply with the Department's directive to change conditions which the Department alleges is deficient under State and/or Federal Long Term Care Regulations. This Plan of Correction should not be construed as either a waiver of the facility's right to appeal or challenge the accuracy or severity of the alleged deficiencies or an admission of past or ongoing violation of State or Federal regulatory requirements. 1. At the time of the finding, the LPN ratios for the current working schedule were reviewed, and no issues were noted. 2. The Director of Nursing and/or designee will educate the RNs and LPNs on the LPN ratios and the importance of monitoring staffing as the day and/or shift progress as well as the ability to substitute an RN for	Completion Date: 05/22/2025 Status: APPROVED Date: 05/08/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395228	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/18/2025
NAME OF PROVIDER OR SUPPLIER: COLE PLACE STATE LICENSE NUMBER: 031802		STREET ADDRESS, CITY, STATE, ZIP CODE: 1001 EAST SECOND STREET COUDERSPORT, PA 16915		
(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 5530	Continued from page 15	P 5530	<p>an LPN; the designated RN charge nurse may take on an assignment and be counted in ratios; A facility such as Cole Place with a census of 59 or under may substitute an LPN for an RN on the overnight shift only if an RN is on call and located within a 30-minute drive of the facility.</p> <p>3. The Director of Nursing and/or designee will audit the current working schedule, and the deployment sheets prior to the day and after the day is complete to ensure compliance.</p> <p>4. Audits will be completed 3 times per week for 1 month, and weekly thereafter for 1 month or until substantial compliance is achieved. Results will be reviewed at the QAPI meeting.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395228	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/18/2025
NAME OF PROVIDER OR SUPPLIER: COLE PLACE STATE LICENSE NUMBER: 031802		STREET ADDRESS, CITY, STATE, ZIP CODE: 1001 EAST SECOND STREET COUDERSPORT, PA 16915		
(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 5530	Continued from page 16 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 40 residents during the overnight shift for one of 21 days reviewed. Findings include: Review of nursing staff care hours provided by the facility for December 28, 2024, through January 3, 2025, February 8 to 14, 2025, and April 10 to 16, 2025, revealed the following LPNs scheduled for the resident census: Night shift (requires one LPN per 40 residents): April 13, 2025, census of 17 with no LPNs, required 1.00 LPN Interview with the Nursing Home Administrator and Director of Nursing on April 16, 2025, at 1:00 PM confirmed that the facility did not meet regulatory LPN-to- resident ratios as evidenced above.	P 5530		



Certified End Page

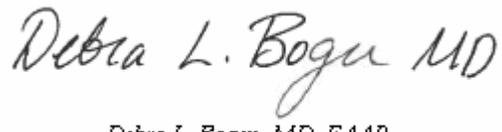
COLE PLACE

STATE LICENSE NUMBER: 031802

SURVEY EXIT DATE: 04/18/2025

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