STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395400	A. BLDG: 00 B. WING:	07/25/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
SUSQUEHANNA HEALTH AND WELLNESS CENTER STATE LICENSE NUMBER: **084802**	**745 OLD CHICKIES HILL ROAD COLUMBIA, PA 17512**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 Based on a Medicare/Medicaid Recertification survey, State Licensure survey, and Civil Rights Compliance survey completed on July 25, 2025 , it was determined that Susquehanna Health and Wellness Center was not in compliance with the following requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities and the 28 PA Code, Commonwealth of Pennsylvania Long Term Care Licensure Regulations.	F 0000		
F 0656 SS=D		F 0656		

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

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

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

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F 0656 SS=D	Continued from page 1 483.21(b)(1)(3) Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future	F 0656	The care plan for R1 was updated to include oxygen therapy. Residents requiring oxygen therapy have had their care plans updated to reflect their current condition. Education will be completed by the DON/Designee with licensed nurses and interdisciplinary team to ensure care plans are updated timely with any changes. The DON/designee will audit 10 resident care plans per week for 4 weeks then monthly times 2 months to ensure that residents requiring oxygen therapy have the appropriate care planned. The results of the audits will be reviewed by the Quality Assessment and Assurance Committee for the need to complete further audits.	Completion Date: 09/11/2025 Status: APPROVED Date: 08/11/2025

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F 0656 SS=D	Continued from page 2 discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by:	F 0656		

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F 0656 SS=D	Continued from page 3 Based on observations, clinical record review and staff interview it was determined that the facility failed to develop a comprehensive care plan for one of 32 residents reviewed (Resident 1). Findings include: Observations on July 22, 2025, at 2:20 p.m. and July 24, 2025, at 12:00 p.m. revealed Resident 1 receiving oxygen via nasal cannula. Review of Resident 1s clinical record revealed no care plan for oxygen use. Interview with the Director of Nursing on July 25, 2025, at 11:23 a.m. confirmed that Resident 1 did not have a care plan for oxygen use. 483.21 Develop/Implement Comprehensive Care Plan Previously cited 8/22/24 28 Pa. Code 211.12(d)(1)(5) Nursing Services Previously cited 8/22/24	F 0656		

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F 0656 SS=D	Continued from page 4	F 0656		
F 0692 SS=D	483.25(g)(1)-(3) Nutrition/Hydration Status Maintenance §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by:	F 0692	R4 is no longer in the facility. R22 has not needed a reweight since May 21, 2025. Residents requiring reweights will be reviewed daily by the dietician and reweights to occur if a change of 5%or more since last weight assessment will be retaken the next day. Education will be completed by the DON/designee with all direct care employees and the interdisciplinary team to ensure that residents requiring reweights are completed timely. The dietician will review all weights per week for 4 weeks then monthly for 2 months to ensure reweights are being completed in a timely manner. The results of the audits will be reviewed by the Quality Assessment and Assurance Committee for the need to complete further audits.	Completion Date: **09/11/2025** Status: **APPROVED** Date: **08/11/2025**

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F 0692 SS=D	Continued from page 5 Based on review of facility policy, review of clinical records and staff interviews, it was determined that the facility failed to maintain acceptable parameters of nutritional status for two of three residents reviewed (Residents 4 and 22). Findings include: Review of facility policy, Weight Assessment and Intervention revised September 2008, revealed monthly weights will be completed no later than the 7th day of the month. Additionally, any weight change of 5% or more since the last weight assessment will be retaken the next day for confirmation. Review of Resident 4s clinical record revealed that the resident weighed 150.0 pounds on April 28, 2025. The resident was admitted to the hospital on April 30, 2025, and readmitted to the facility on May 8, 2025. Review of a weight warning note on May 9, 2025, revealed a weight of 181.3 pounds and indicated a suspected discrepancy in weight. A reweight was	F 0692		

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F 0692 SS=D	Continued from page 6 requested. Review of the clinical record revealed a reweight of 135.0 pounds was obtained on May 20, 2025 (11 days later). Interview with Employee E3 on July 24, 2025, at 9:40 a.m. confirmed that Resident 4s reweight was not completed timely after the readmission discrepancy. Review of Resident 22s clinical record revealed that the resident weighed 96.8 pounds on February 1, 2025 and 88.4 pounds (decrease of 8.4 pounds or 8.7% decrease) on March 5, 2025. Review of weight warning note of March 6, 2025, indicated suspected significant weight change and a reweight was requested. Review of the clinical record revealed that a reweight of 85.6 pounds was obtained on March 19, 2025 (14 days later). Review of Resident 22s clinical record revealed a weight of 92.6 pounds on April 8, 2025 (increase of 7.0 pounds or 8.3% since previous weight). There was no documented evidence that a reweight was obtained. Review of Resident 22s clinical record revealed a weight of 81.0 pounds on May 15, 2025 (decrease	F 0692		

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F 0692 SS=D	Continued from page 7 of 11.6 pounds or 12.5% since previous weight). Review of weight warning note of May 16, 2025, revealed suspected significant weight change from previous month and a reweight was requested. A reweight of 78.6 pounds was obtained on May 21, 2025 (5 days later). Interview with Employee E3 on July 24, 2025, at 11:25 a.m. indicated that reweights should be done as soon as possible. Employee E3 indicated that a reweight for Resident 22s April 2025 weight was not completed because the weight change did not trigger for a reweight. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services	F 0692		
F 0695 SS=D		F 0695		

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F 0695 SS=D	Continued from page 8 483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by:	F 0695	R1's orders were updated to reflect the use of oxygen therapy. Residents requiring oxygen therapy had their orders reviewed for oxygen use. Education will be completed by DON/designee with all licensed staff to ensure physician orders are placed when oxygen therapy is ordered. The DON/designee will review 5 residents per week for 4 weeks then monthly for 2 months to ensure residents with oxygen therapy have physician orders entered. The results of the audits will be reviewed by the Quality Assessment and Assurance Committee for the need to complete further audits.	Completion Date: **09/11/2025** Status: **APPROVED** Date: **08/11/2025**

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F 0695 SS=D	Continued from page 9 Based on observations, clinical record review and staff interview it was determined that the facility failed to ensure respiratory care was provided consistent with professional standards of practice for one of one resident reviewed (Resident 1). Findings include: Observations on July 22, 2025, at 2:20 p.m. and July 24, 2025, at 12:00 p.m. revealed Resident 1 receiving oxygen via nasal cannula (tube that delivers oxygen) at a flow rate of 2.0 liters per minute. Review of Resident 1s clinical record revealed no order for oxygen or respiratory care. Interview with the Director of Nursing on July 25, 2025, at 11:23 a.m. confirmed that Resident 1 did not have an order for oxygen use. 483.25 Respiratory/Tracheostomy Care and Suctioning Previously cited 3/5/25, 8/22/24 28 Pa. Code 211.12(d)(3)(5) Nursing Services Previously cited 8/22/24	F 0695		
F 0725 SS=D		F 0725		

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F 0725 SS=D	Continued from page 10 483.35(a)(1)(2) Sufficient Nursing Staff §483.35 Nursing Services. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity, and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71. §483.35(a) Sufficient Staff. §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (f) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (f) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by:	F 0725	1. Licensed nurse was educated on sleeping and received disciplinary action for sleeping. Nursing staff on B wing were educated on timely tray pass and call light response time. 2. Call response times have been reviewed with resident council members to ensure timely response. 3. Education will be completed by the DON/designee with all direct care staff and interdisciplinary team related to call light response, congregating at nurses' station, sleeping, and meal tray delivery. 4. The DON/designee will review call bell response times, sleeping, congregating at nurses' station, and meal tray delivery three days per week for 4 weeks then monthly for 2 months. The results of the audits will be reviewed by the Quality Assessment and Assurance Committee for the need to complete further audits.	Completion Date: **09/11/2025** Status: **APPROVED** Date: **08/11/2025**

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F 0725 SS=D	Continued from page 11	F 0725		

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F 0725 SS=D	Continued from page 12 Based upon observation, it was determined that the facility failed to ensure adequate and competent staffing levels were maintained to promptly respond to resident call bells on one day of three days of the survey. Findings include: Observation on July 23, 2025, at 12:07 p.m. on the B Wing nursing unit revealed five resident call bells with the lights on and audibly ringing, as well as lunch carts in the hallway that had been delivered to the unit from the kitchen. Observation of the B Wing nursing unit nurses station on July 23, 2025, at 12:07 p.m. revealed four employees gathered in a side room with the door closed. Further observation of the B Wing nursing unit nurses station on July 23, 2025, at 12:07 p.m. revealed a licensed employee sleeping in front of the computer at the desk. Observation of the B Wing resident call bells revealed the resident call bells remained unanswered and the lunch trays not delivered for approximately 15 minutes. The above information was conveyed to the Nursing Home Administrator and Director of Nursing on July 25, 2025, at 11:30 a.m. 28 Pa. Code 201.18(b)(1)(2)(5)(e)(1) Management Previously cited 8/22/2024 28 Pa. Code 201.29(c)(4) Resident Rights Previously cited 8/22/2024 28 Pa. Code 211.12(d)(1)(5) Nursing Services	F 0725		

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F 0725 SS=D	Continued from page 13 Previously cited 8/22/2024	F 0725		
F 0730 SS=E	483.35(e)(7) Nurse Aide Peform Review-12 hr/yr In-Service §483.35(e)(7) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g). This REQUIREMENT is not met as evidenced by:	F 0730	Performance reviews were completed on E4, E5, E6, E7, E8. Current nurse aide files were reviewed and follow up completed as needed. Education will be completed by the Administrator/designee with supervisors and interdisciplinary team to ensure performance reviews are completed based off the employees hire date. The DON/designee will review nurse aide performance reviews are completed based off their hire date for weekly for 4 weeks then monthly for 2 months. The results of the audits will be reviewed by the Quality Assessment and Assurance Committee for the need to complete further audits.	Completion Date: **09/11/2025** Status: **APPROVED** Date: **08/11/2025**

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F 0730 SS=E	Continued from page 14 Based on review of facility documentation and staff interviews it was determined that the facility failed to complete a performance review at least once every 12 months for five of five nurse aides (Employees E4, E5, E6, E7, and E8). Findings include: Review of Employee E4s personnel record revealed a date of hire of October 11, 2023. Review of Employee E5s personnel record revealed a date of hire of May 24, 2023. Review of Employee E6s personnel record revealed a date of hire of June 8, 2022. Review of Employee E7s personnel record revealed a date of hire of September 3, 2019. Review of Employee E8s personnel record revealed a date of hire of October 6, 2021. Further review of the personnel records revealed no evidence that the employees had a performance review at least once every 12 months. Interview with the Nursing Home Administrator and Director of Nursing on July 25, 2025, at 10:10 a.m. confirmed that performance reviews had not been completed for the above employees. 28 Pa. Code 201.19(2) Personnel policies and procedures	F 0730		

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	395400	A. BLDG: __00_____ B. WING: _____	07/25/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
SUSQUEHANNA HEALTH AND WELLNESS CENTER	**745 OLD CHICKIES HILL ROAD COLUMBIA, PA 17512**
STATE LICENSE NUMBER: **084802**	

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F 0730 SS=E	Continued from page 15	F 0730		
F 0761 SS=D	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by:	F 0761	The 5 undated/expired insulin pens/vial were discarded. An audit was completed of the medication cart to ensure that insulin pens/vials are dated when opened and undated/expired are discarded immediately. Education will be completed by the DON/designee for licensed nurses on the policy for dating medications with shortened expiration dates when open. The DON/designee will audit 6 medication carts to ensure insulin pens/vials are dated weekly for 4 weeks then monthly for 2 months. The results of the audits will be reviewed by the Quality Assessment and Assurance Committee for the need to complete further audits.	Completion Date: **09/11/2025** Status: **APPROVED** Date: **08/11/2025**

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F 0761 SS=D	Continued from page 16	F 0761		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0761 SS=D	Continued from page 17 Based on review of facility policies and procedures and observation, it was determined that the facility failed to ensure medications were properly labeled with open and expiration dates and failed to ensure expired medications were not administered for one of three medication carts reviewed (B Wing Medication Cart). Findings include: Based upon facility policy and procedure titled Storage of Medications revealed Discontinued, outdated, or deteriorated drugs or biologicals are returned to the dispensing pharmacy or destroyed. Review of facility policy and procedure titled Administering Medications revealed The expiration/beyond use date on the medication label is checked prior to administering. When opening a multi-dose container, the date opened is recorded on the container. Review of package insert instructions for Humalog Insulin (medication used to treat high blood sugar levels) Pens revealed unopened Humalog pens should be stored in the refrigerator. Further review of package insert instructions for Humalog Insulin Pens revealed that once opened, Humalog can be kept at room temperature for up to 28 days. Review of package insert instruction for Lantus Insulin (medication used to treat high blood sugar levels) revealed Lantus Insulin should be used within 28 days after opening. Review of package insert instructions for Insulin Aspart	F 0761		

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F 0761 SS=D	Continued from page 18 (Novolog insulin) (medication used to treat high blood sugar levels) revealed that Insulin Aspart expires 28 days after opening. Review of package insert instructions for Insulin glargine (medication used to treat high blood sugar levels) revealed Insulin glargine must be discarded 28 days after opened. Observation of the B Wing Medication Cart on July 24, 2025, at 11:00 a.m. revealed a Humalog Insulin Pen opened on June 20, 2025, with no expiration date. The expiration date for this Humalog Insulin Pen would have been July 17, 2025, 28 days after opening the pen. Further observation revealed an unopened and undated Humalog Insulin Pen in the medication drawer. Further observation revealed two open and undated insulin aspart pens. Further observation revealed one open and undated insulin glargine vial. 28 Pa. Code 211.12(c)(d)(1)(3)(5) Nursing Services Previously cited 8/22/2024, 3/5/2025	F 0761		

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F 0880 SS=E		F 0880		

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F 0880 SS=E	Continued from page 20 483.80(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	E9 had a medication competency completed. R6, R22, R136 were placed on Enhanced barrier Precautions. PPE and signage placed for each resident. Residents requiring Enhanced Barrier Precautions related to pressure injuries were reviewed for proper signage and PPE was available. Education will be completed by the DON/designee for all direct care staff and interdisciplinary team on Enhanced Barrier Precautions use for Pressure Injuries. Licensed Staff will be educated on following infection control practice during medication administration. The DON/designee will audit 5 residents that require Enhanced barrier Precautions weekly for 4 weeks then monthly for 2 months to ensure precautions are being utilized, proper PPE available, and	Completion Date: 09/11/2025 Status: APPROVED Date: 08/11/2025

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F 0880 SS=E	Continued from page 21 (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	signage posted for all pressure injuries/wounds. Five medication administration audits will be completed for 4 weeks then monthly for 2 months. The results of the audits will be reviewed by the Quality Assessment and Assurance Committee for the need to complete further audits.	

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F 0880 SS=E	Continued from page 22	F 0880		

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F 0880 SS=E	Continued from page 23 Based upon review of facility policy and procedure, observation and clinical record review, it was determined that the facility failed to ensure proper infection control procedures were followed during medication administration observation and pressure ulcer wound treatments for three of three residents observed (Resident 6, Resident 22 and Resident 136.) Findings include: Review of facility policy and procedure titled Administering Medications revealed "Staff follows established facility infection control procedures (e.g. handwashing, aseptic technique, gloves, isolation precautions, etc) for the administration of medications, as applicable." Observation of Medication Administration on July 22, 2025, at 11:44 a.m. revealed Licensed Employee E9 placing medication pills for administration into Licensed Employee E9's ungloved hands and then placing the medication pill into the medication cup for administration. Observations on all days of the survey revealed no system in place to communicate to staff that resident required enhanced barrier precautions. Additionally, no PPE (personal protective equipment) was readily available to staff providing high contact care. Review of resident 6's progress notes on July 24, 2025, revealed resident had a stage III pressure ulcer to the sacrum (bone at the bottom of the spine). Observations of Resident 6's room showed no indication of	F 0880		

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F 0880 SS=E	Continued from page 24 enhanced barrier precautions being communicated to staff entering the room. No PPE was observed to be available to staff providing care to Resident 6. Observation of Resident 6's wound care on July 25, 2025, at 11:28 a.m. revealed Licensed Employee E10 failed to utilize Personal Protective Equipment during the wound dressing change. Review of Resident 22's progress note of July 15, 2025, revealed resident had a stage II pressure ulcer (wound with partial thickness skin loss) to the sacrum (triangular bone at the base of the spine). Observation of Resident 22's wound care on July 25, 2025, at 10:17 a.m. revealed Licensed Employee E10 failed to utilize Personal Protective Equipment during the wound dressing change. Review of resident 136's progress notes on May 6, 2025, revealed resident had a stage III pressure ulcer to the sacrum (wound full-thickness skin loss) to the sacrum (triangular bone at the base of the spine). Observations of Resident 136's room showed no indication of enhanced barrier precautions being communicated to staff entering the room. No PPE was observed to be available to staff providing care to Resident 136. Observation of Resident 136's wound care on July 24, 2025, at 9:40 a.m. revealed Licensed Employee E10 failed to utilize Personal Protective Equipment during the wound dressing change. The above information was conveyed to the Nursing Home Administrator and Director of Nursing on July 25, 2025, at	F 0880		

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F 0880 SS=E	Continued from page 25 11:00 a.m.	F 0880		

Certified End Page

SUSQUEHANNA HEALTH AND WELLNESS CENTER

STATE LICENSE NUMBER: 084802

SURVEY EXIT DATE: 07/25/2025

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
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