

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395831	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 08/05/2025
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NAME OF PROVIDER OR SUPPLIER: SCHUYLKILL CENTER STATE LICENSE NUMBER: 453002	STREET ADDRESS, CITY, STATE, ZIP CODE: 1000 SCHUYLKILL MANOR ROAD POTTSVILLE, PA 17901
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F 0000	INITIAL COMMENT	F 0000		
F 0550 SS=D	Based on an Abbreviated survey in response to three complaints completed on August 5, 2025, it was determined that Schuylkill Center was not in compliance with the following requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care and the 28 Pa. Code, Commonwealth of Pennsylvania Long Term Care Licensure Regulations.	F 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.

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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 will continue to provide a reasonable accommodation of needs. 1. R3 , upon notification was followed up with by unit manager and has no further concerns 2. Call bell response time was addressed at resident council on 8/5/2025. Concerns addressed and call bell response time audits will be initiated. 3. The Director of Nursing or designee will provide nursing staff education on call bells response time and addressing the needs of residents. 4. A call bell audit will be completed by Director of Nursing or designee for 20 residents weekly for 4 weeks, with results communicated to the QAPI Committee. 5. Date of compliance is 08/20/2025.	Completion Date: 08/20/2025 Status: APPROVED Date: 08/21/2025

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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		
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F 0550 SS=D	Continued from page 3 Based on clinical record review, observation, and staff and resident interview, it was determined that the facility failed to provide a reasonable accommodation of needs for one of seven sampled residents. (Resident 3) Findings include: Clinical record review revealed that Resident 3 had diagnoses that included hemiparesis and unsteadiness on feet. Review of the care plan revealed that the resident required assistance from two staff and a mechanical lift for transfers, assistance from two staff for toileting (staff were to provide assistance with toileting as needed), and that the resident had been educated to call staff for assistance. On August 5, 2025, at 11:09 a.m., the residents call bell was observed to be lit outside the room. At 11:15 a.m., the call bell remained activated. At that time, Resident 3 stated that she rang the call bell to notify staff that she required assistance to the bathroom; a staff member told her they would return with another staff member to	F 0550		

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F 0550 SS=D	Continued from page 4 provide assistance, but no one had returned. The residents call bell continued to remain lit at 11:40 a.m., and at that time, Resident 3 stated that no staff member had returned to offer assistance. Staff did not return to Resident 3s room to provide assistance until 11:48 a.m., 39 minutes after the residents call bell was initially observed to have been activated. In an interview on August 5, 2025, at 1:52 p.m., the Director of Nursing confirmed that staff were to provide a timelier response to the call bell. 28 Pa. Code 211.12(d)(1)(5) Nursing services.	F 0550		
F 0684 SS=D		F 0684		

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F 0684 SS=D	Continued from page 5 483.25 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 will continue to implement physicians orders. 1. R1 no longer resides at facility. R2's MD and RP were notified of elevated BP on 7/11/2025 and 7/26/2025 and PRN not administered. No negative outcome to R2 noted. 2. Facility audit completed for like residents with sliding scale and blood pressure orders with parameters. 3. The Director of Nursing or designee will provide licensed nurses education on ensuring orders with parameters are being followed and have proper prompts, and notifying MD and RP . 4. The Director of Nursing/designee will audit cardiac medications and sliding scale orders weekly for 4 weeks. Results of audits will be reported to the QAPI Committe. 5. Date of compliance is 08/20/2025.	Completion Date: 08/20/2025 Status: APPROVED Date: 08/21/2025

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F 0684 SS=D	Continued from page 6 Based on clinical record review and staff interview, it was determined that the facility failed to implement physicians orders for two of seven sampled residents. (Residents 1 and 2) Findings include: Clinical record review revealed that Resident 1 had diagnoses that included diabetes mellitus. Review of the care plan revealed that staff were to obtain glucometer (device used to measure blood glucose levels) readings and report abnormalities as ordered. A physicians order dated July 11, 2025, directed staff to inject insulin lispro per sliding scale orders and notify the physician for a blood glucose reading of 400 milligrams per deciliter (mg/dL) or higher. Review of Resident 1s clinical record revealed that on July 11, 2025, staff noted a blood glucose level of 438 mg/dL at 5:01 p.m. There was no evidence that the residents physician was notified of the blood glucose reading that was above 400 mg/dL, per the physicians order.	F 0684		

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F 0684 SS=D	Continued from page 7 In an interview on August 5, 2025, at 3:10 p.m., the Director of Nursing (DON) confirmed that there was no evidence that staff notified the residents physician of the blood glucose level of 438 mg/dL, per the physicians order. Clinical record review revealed that Resident 2 had diagnoses that included hypertension (high blood pressure). Physicians orders dated April 6, 2025, and May 1, 2025, directed staff to check the residents blood pressure twice per day and administer clonidine (a medication to treat high blood pressure) as needed, every eight hours if Resident 2s systolic blood pressure was greater than 160 millimeters of mercury (mm Hg), or diastolic blood pressure was greater than 100 mm Hg. Review of Resident 2s clinical record revealed that on July 10, 2025, at 6:14 p.m., staff noted the residents blood pressure to have been 165/89 mm Hg. On July 26, 2025, at 8:04 a.m., staff noted the residents blood pressure as 187/107 mm Hg. There was no evidence that staff administered the clonidine at those times on July 10 and 26, 2025, when the	F 0684		

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F 0684 SS=D	Continued from page 8 residents systolic blood pressure was greater than 160 mm Hg, and diastolic blood pressure was greater than 100 mm Hg, per the physicians order. In interviews on August 5, 2025, at 3:28 p.m. and 3:38 p.m., the DON confirmed that there was no evidence that staff administered the medication when the residents systolic blood pressure was greater than 160 mm Hg and diastolic blood pressure was greater than 100 mm Hg, per the physicians order. 28 Pa. Code 211.12(d)(1)(5) Nursing services.	F 0684		

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P 5520	<p>Nursing services.</p> <p>(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.</p> <p>This REGULATION is not met as evidenced by:</p>	P 5520	<ol style="list-style-type: none"> C.N.A. ratios for the dates noted in the survey cannot be corrected as this is a past event. Calculation of shift C.N.A. ratios will be completed and reviewed daily for accuracy by the scheduler. The facility has developed internal incentives to retain and attract new staff. The facility continues to attend job fairs and nursing schools to recruit direct care staff, in addition to other ongoing recruiting initiatives. Facility continues with an employee referral program to recruit staff also. Agency staff are being utilized in an effort to reach daily shift ratios. The scheduler will look ahead for a minimum of 1 week at projected staffing patterns to enable more time to achieve appropriate C.N.A. ratios as needed. C.N.A. ratios will be audited by scheduler and DON daily for 4 weeks, then 3 days per week x 2 months or until substantial compliance is achieved. Results will be reported to QAPI committee. Date of correction is 08/20/2025. 	<p>Completion Date: 08/20/2025</p> <p>Status: APPROVED</p> <p>Date: 08/21/2025</p>
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P 5520	Continued from page 1 Based on a review of nursing time schedules, it was determined that the facility failed to meet the minimum nurse aide (NA) to resident ratios for seven of 21 days reviewed. Findings include: Review of nursing schedules from July 14, 2025, through August 3, 2025, revealed the following: The facility failed to meet the minimum NA to resident ratio of one NA for ten residents on day shift (7:00 a.m. to 3:00 p.m.) on July 20 and 27, 2025. The facility failed to meet the minimum NA to resident ratio of one NA for eleven residents on evening shift (3:00 p.m. to 11:00 p.m.) on July 18, 20, 21, 25, 27, and 31, 2025, and August 1, 2025. The facility failed to meet the minimum NA to resident ratio of one NA for 15 residents on the night shift (11:00 p.m. to 7:00 a.m.) on July 27,	P 5520		

Pennsylvania Department of Health

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P 5520	Continued from page 2 2025.	P 5520		
P 5530		P 5530		

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P 5530	Continued from page 3 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	<ol style="list-style-type: none"> LPN ratios for the dates noted in the survey cannot be corrected as this is a past event. Calculation of shift LPN ratios will be completed and reviewed daily for accuracy by the scheduler. The facility has developed internal incentives to retain and attract new staff. Facility has scheduled recruitment appearances at LPN schools to recruit new staff, and introduced employee referral program. Recruitment outreach via social media and messaging to area LPNs encourage joining our facility staff. Agency staff are being utilized in an effort to reach daily shift ratios. The scheduler will look ahead for a minimum of 1 week at projected staffing patterns to enable more time to achieve appropriate LPN ratios as needed. LPN ratios will be audited by scheduler and DON daily for 4 weeks, then 3 days per week x 2 months or until substantial compliance is achieved. Results will be reported to QAPI committee. Date of correction is 08/20/2025. 	Completion Date: 08/20/2025 Status: APPROVED Date: 08/21/2025

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P 5530	Continued from page 4 Based on a review of nursing time schedules, it was determined that the facility failed to meet the minimum licensed practical nurse (LPN) to resident ratios for five of 21 days reviewed. Findings include: Review of nursing schedules from July 14, 2025, through August 3, 2025, revealed the following: The facility failed to meet the minimum LPN to resident ratio of one LPN for 25 residents on the day shift (7:00 a.m. to 3:00 p.m.) on July 26 and 27, 2025, and August 2 and 3, 2025. The facility failed to meet the minimum LPN to resident ratio of one LPN for 30 residents on the evening shift (3:00 p.m. to 11:00 p.m.) on August 1, 2025. The facility failed to meet the minimum LPN to resident ratio of one LPN for 40 residents on the night shift (11:00 p.m. to 7:00 a.m.) on August 3,	P 5530		

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P 5530	Continued from page 5 2025.	P 5530		
P 5640		P 5640		

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P 5640	Continued from page 6 Nursing services. (2) Effective July 1, 2024, the total number of hours of general nursing care provided in each 24-hour period shall, when totaled for the entire facility, be a minimum of 3.2 hours of direct resident care for each resident. This REGULATION is not met as evidenced by:	P 5640	<ol style="list-style-type: none"> Nursing hours noted in the survey cannot be corrected as this is a past event. Calculation of daily PPD will be completed and reviewed daily for accuracy by the scheduler. The facility has developed internal incentives to retain and attract new staff. Facility recently completed nurse aide training classes to fill vacant nurse aide positions. LPN school recruitment efforts continue with presentation scheduled this fall to graduating LPNs. Continue with collaboration with local Penn State campus to introduce graduating nurses to long term care in our facility. Agency contracts are in place in an effort to reach daily PPD requirements. The scheduler will look ahead for a minimum of 1 week to determine projected PPD to allow more time to achieve PPD hours requirements. PPD hours will be audited by scheduler and DON daily for 4 weeks, then 3 days per week x 2 months, or until substantial compliance is achieved. Results will 	Completion Date: 08/20/2025 Status: APPROVED Date: 08/21/2025

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
P 5640	Continued from page 7	P 5640	be reviewed at QAPI meeting. 5. Date of compliance is 08/20/2025.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395831	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 08/05/2025
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P 5640	Continued from page 8 Based on a review of nursing time schedules, it was determined that the facility failed to provide a minimum of 3.2 direct care hours for each resident for 12 of 21 days reviewed. Findings include: Review of nursing schedules for 21 days from July 14, 2025, through August 3, 2025, revealed the following: July 16, 2025: 3.16 care hours per resident July 17, 2025: 3.11 care hours per resident July 18, 2025: 3.09 care hours per resident July 20, 2025: 2.96 care hours per resident July 21, 2025: 2.96 care hours per resident July 24, 2025: 3.10 care hours per resident	P 5640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395831	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 08/05/2025
NAME OF PROVIDER OR SUPPLIER: SCHUYLKILL CENTER STATE LICENSE NUMBER: 453002		STREET ADDRESS, CITY, STATE, ZIP CODE: 1000 SCHUYLKILL MANOR ROAD POTTSVILLE, PA 17901		
(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 5640	Continued from page 9 July 25, 2025: 3.01 care hours per resident July 27, 2025: 2.72 care hours per resident July 31, 2025: 3.10 care hours per resident August 1, 2025: 3.14 care hours per resident August 2, 2025: 3.0 care hours per resident August 3, 2025: 2.91 care hours per resident	P 5640		



Certified End Page

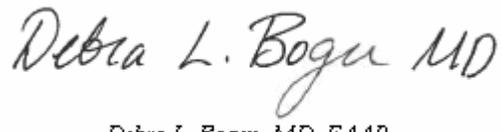
SCHUYLKILL CENTER

STATE LICENSE NUMBER: 453002

SURVEY EXIT DATE: 08/05/2025

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