STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396137	A. BLDG: 00 B. WING:	07/03/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
ATHENS NURSING AND REHABILITATION CENTER STATE LICENSE NUMBER: **24210201**	**200 SOUTH MAIN ST.** **ATHENS, PA 18810**

(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 3, 2025, it was determined that Athens Nursing and Rehabilitation 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 0000		
F 0578 SS=D		F 0578		

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

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

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

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F 0578 SS=D	Continued from page 1 483.10(c)(6)(8)(g)(12)(i)-(v) Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance	F 0578	1. Resident 28's Advanced Directive was immediately clarified with resident and signed by MD. Information was updated in resident orders, special instructions and Care Plan. Resident 28's Advanced Directive was uploaded into electronic medical record. 2. An audit of all resident's POLST was completed to ensure resident order, special instructions and Care Plan matched wishes expressed on signed POLST form. 3. All new or amended POLST form will have an order immediately entered in PCC. Care Plan and special instructions will be updated. Any new/amended POLST will be uploaded to the "Document" tab in residents electronic medical chart. All Licensed Staff will be educated on immediately entering/amending order, special instructions, and CP based on POLST form. All existing resident POLST will be uploaded into residents electronic record.	Completion Date: **08/12/2025** Status: **APPROVED** Date: **07/23/2025**

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F 0578 SS=D	Continued from page 2 directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by:	F 0578	4. Audits will be conducted of any admissions or updated POLST, daily 4x a week, weekly for 4 weeks and monthly x2 by the Administrator/designee to ensure compliance. Results of the audits will be presented at the QAPI meetings for review and to ensure ongoing compliance.	

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F 0578 SS=D	Continued from page 3 Based on clinical record review and staff interview, it was determined that the facility failed to establish clear advance directives for one of 24 residents reviewed (Resident 28). Findings include: Clinical record review for Resident 28 revealed a physician's order dated May 28, 2025, indicating the resident was to be a DNR (do not resuscitate, do not perform CPR (cardiopulmonary resuscitation) if the person has no pulse and is not breathing). Record review for Resident 28 also revealed a POLST (Pennsylvania orders for lift sustaining treatment) dated May 7, 2025, that indicated Resident 28 desired to be a full code (attempt CPR when the person has no pulse and is not breathing). The POLST was signed by the resident. There was no documented evidence identified or provided by facility staff to indicate Resident 28	F 0578		

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F 0578 SS=D	Continued from page 4 completed an updated POLST after May 7, 2025, or had discussions with facility staff or the physician indicating a change in wishes for life sustaining treatment was desired. The above information regarding Resident 28 was reviewed during an interview with the Nursing Home Administrator and Director of Nursing on July 2, 2025, at 12:05 PM. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services	F 0578		
F 0583 SS=E		F 0583		

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F 0583 SS=E	Continued from page 5 483.10(h)(1)-(3)(i)(ii) Personal Privacy/Confidentiality of Records §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(h)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in	F 0583	1. Facility is unable to retroactively correct staff members using personal computers for documentation purposes. 2. Staff were provided additional facility issued laptops/POC documentation devices. 3. Administrator checked status of laptops previously ordered and expected delivery date. Additional laptops were also purchased/un-used facility laptops/desktops were provided to nursing units. All nursing staff will be re-educated on HIPPA/only using facility provided computer equipment. 4. Random audits will be conducted to ensure only facility issued computers are being used, 2x a day, 3x a week, then weekly for 4 weeks. Administrator/designee to ensure compliance. Results of the audits will be presented at the QAPI meetings for review and to ensure	Completion Date: **08/12/2025** Status: **APPROVED** Date: **07/23/2025**

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F 0583 SS=E	Continued from page 6 accordance with State law. This REQUIREMENT is not met as evidenced by:	F 0583	ongoing compliance.	

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F 0583 SS=E	Continued from page 7 Based on observation and staff interview, it was determined that the facility failed to ensure resident's privacy during a medication pass while utilizing staff personal electronic devices for two of two nursing units (Ivy and Sage Nursing Units) for one of 19 sampled residents (Residents 20). Findings include: Review of facility documentation entitled, "Athens Nursing and Rehabilitation Center Orientation," revealed that all staff attend and review this orientation upon hire. The orientation documentation revealed that staff received education on the HIPPA (Health insurance Portability and Accountability) Act of 1996, confidentiality, privacy, and resident rights. HIPPA "protects protective sensitive patient information from being disclosed without their consent or knowledge. A HIPPA violation is punishable by law and could be subject to fines or jail time." Residents have the right to "have their personal information kept private."	F 0583		

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F 0583 SS=E	Continued from page 8 Interview with the Nursing Home Administrator (NHA) on July 2, 2025, at 2:200 PM confirmed that staff complete orientation and that this information was reviewed during mandatory yearly in-services as well. Review of Employee 5, LPN (licensed practical nurse), Employee 6, NA (nurse aide), and Employee 7, NA's employee file revealed Employee 5 completed their orientation/in-service training on March 6, 2025, Employee 6 completed their orientation/in-service training on September 10, 2024, and Employee 7 completed their orientation/in-service training on June 18, 2025. Observation of the Ivy nursing unit on July 2, 2025, at 9:04 AM revealed that Employee 5 was passing medications to Resident 20. Employee 5 was utilizing the facility's identified electronic documentation system (point click care, PCC) to access Resident 20's medical record to identify, administer, and chart their medications. Concurrent interview with Employee 5 revealed that they	F 0583		

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F 0583 SS=E	Continued from page 9 accessed Resident 20's medical record via their own personal electronic device that they bring from home to work. Employee 5 indicated that there are not enough facility supplied electronic devices on the Ivy nursing to access resident medical records to timely administer medications and document on residents; therefore, she brings her own electronic device to ensure she has access when needed. Observation of the Sage nurse's station and interview with Employee 7, NA on July 2, 2025, at 10:05 AM revealed that there were four facility supplied laptops available for staff use. When questioned if anyone had brought a personal electronic device from home to chart or document in a resident record Employee 7 indicated that they had brought their own electronic device into the facility to utilize. Interview with the NHA on July 2, 2025, at 11:45 AM confirmed there was a concern with staff accessing resident clinical records via their personal electronic devices due to HIPPA, confidentiality,	F 0583		

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F 0583 SS=E	Continued from page 10 and resident privacy. The NHA requested that their corporate office purchase four laptops on June 24, 2025, due to only having two laptops available at the time for six to seven NAs to chart with. At the time of the interview, the facility had not received the requested laptops Observation of the Ivy nurse's station and interview with Employee 5 on July 2, 2025, at 11:50 AM revealed that the nursing unit was supposed to have two laptops and one iPad for staff usage. Observation of the station revealed one facility supplied laptop (labeled Sage) and one facility supplied iPad were available. Employee 5 revealed that she was unsure where the second laptop was located. At the time of the observation, there was a personal iPad, identified to be owned by Employee 6, NA, lying on the nurse's station desk, which staff utilize to chart care and services in resident records. Review of the staffing schedule for July 2, 2025, day shift, revealed that there were eight NAs, three LPNs and one RN working to share the five facility	F 0583		

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F 0583 SS=E	Continued from page 11 supplied laptops and one facility supplied iPad to chart care and services in resident's clinical record. The facility was unable to ensure that resident personal and private information contained in a resident's clinical record was secure due to staff utilizing their own personal electronic devices and accessing residents clinical records. 28 Pa. Code 201.29 (c.3)(4) Resident rights	F 0583		
F 0584 SS=D		F 0584		

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F 0584 SS=D	Continued from page 12 483.10(i)(1)-(7) Safe/Clean/Comfortable/Homelike Environment §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all	F 0584	1. Any dried liquid observed on the lower portion of the wall behind Med Carts were cleaned the day of survey. The vent above Sage Nursing Station was cleaned the day of Survey. Resident 27's and Resident 66's wall next to the bathroom door has been fixed, under the hand sanitizer dispenser. The handrails have been painted on Sage Hallway. 2. A whole house room audit was completed to identify any other resident rooms that drywall is exposed. A whole house audit was also completed to ensure no vents had a buildup of dust, and no walls had dried liquid present. 3. Areas that drywall is exposed will be fixed, vents and walls will be cleaned to ensure a clean, home-like environment. Housekeeping and Nursing staff will be educated to ensure walls are clean. Maintenance Staff will be educated on fixing exposed drywall, painting hand rails when metal is exposed and	Completion Date: **08/12/2025** Status: **APPROVED** Date: **07/23/2025**

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F 0584 SS=D	Continued from page 13 areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by:	F 0584	maintaining clean vents. 4. Environmental audits will be conducted of the Sage Hallway/Nursing Station, daily 4x a week, weekly for 4 weeks and monthly x2 by the Administrator/designee to ensure compliance. Results of the audits will be presented at the QAPI committee to ensure ongoing compliance.	

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F 0584 SS=D	Continued from page 14 Based on observation and staff interview, it was determined that the facility failed to provide a clean, comfortable, homelike environment on one of two nursing units (Sage; Residents 27 and 66). Findings include: Observation on July 1, 2025, at 11:42 AM revealed Resident 27's room had damage to the wall next to the bathroom door. There was 10 to 12 inches of exposed drywall paper. A hand sanitizer dispenser was installed, covering a portion of the damaged area. Observation on July 1, 2025, at 11:55 AM of Resident 66 room revealed a 2-inch area of exposed drywall paper on the wall next to the bathroom door. A hand sanitizer dispenser was installed, covering a portion of the damaged area. Observation of the Sage Nursing unit hallway on July 1, 2025, at 12:05 PM revealed a painted handrail with the paint rubbed off, exposing the	F 0584		

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F 0584 SS=D	Continued from page 15 underlying metal. This damage was most severe at the intersection of two hallways, next to the nursing station. Dried brown liquid splatter was observed on the lower portion of the wall behind two medication carts located across from the nursing station. A vent above the nursing station contained visible dust hanging on the interior and exterior of the vent extending to the surrounding ceiling tiles. The surveyor reviewed the above findings with the Nursing Home Administrator and the Director of Nursing on July 2, 2025, at 11:58 AM. 483.10(i) Housekeeping and Maintenance Services 28 Pa. Code 201.18(b)(3)(e)(2.1) Management	F 0584		
F 0628 SS=C		F 0628		

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	396137	A. BLDG: 00 B. WING:	07/03/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
ATHENS NURSING AND REHABILITATION CENTER STATE LICENSE NUMBER: **24210201**	**200 SOUTH MAIN ST.** **ATHENS, PA 18810**

(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 0628 SS=C	Continued from page 16 483.15(c)(2)(iii)(3)-(6)(8)(d)(1)(2); 483.21(c)(2)(i)-(iii) Discharge Process §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i) (A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must-	F 0628	1. The State Long Term Care Ombudsman will be notified via email of the transfers of Residents 13, 23, 26, 28, 50, 55, 57, 64, and 66. 2. NHA/designee will audit the facility-initiated transfers for the last 30 days to ensure that the Office of the State Long-Term Care Ombudsman was notified. 3. Social Service Director/designee will maintain a log of residents transferred from the facility. Monthly, the NHA/designee will audit the log to ensure compliance and SSD will submit the log to the Office of the State Long-Term Care Ombudsman. The date of notification will be recorded on the audit form. 4. All hospital transfers will be reviewed in AM meeting 4x a week for 4 weeks, and weekly x2 months to ensure written notification was provided The State Long Term Care Ombudsman. Results of the audits will be presented at the Quality	Completion Date: **08/12/2025** Status: **APPROVED** Date: **07/23/2025**

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F 0628 SS=C	Continued from page 17 (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days.	F 0628	Assurance Performance Improvement meetings for review and to ensure ongoing compliance.	

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F 0628 SS=C	Continued from page 18 §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy	F 0628		

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F 0628 SS=C	Continued from page 19 for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any;	F 0628		

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F 0628 SS=C	Continued from page 20 (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter).	F 0628		

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F 0628 SS=C	Continued from page 21 This REQUIREMENT is not met as evidenced by:	F 0628		

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F 0628 SS=C	Continued from page 22 Based on clinical record review and staff interview, it was determined that the facility failed to notify the Office of the State Long-Term Care Ombudsman upon transfer to the hospital for nine of 10 residents reviewed for hospitalizations (Residents 13, 23, 26, 28, 50, 55, 57, 64, and 66). Findings include: Clinical record review for Resident 23 revealed nursing documentation dated April 8, 2025, at 9:15 AM that noted the resident was sent to the hospital due to chest pain. Nursing documentation for Resident 23 revealed a health status note dated April 9, 2025, at 9:21 AM that noted the resident was admitted to the hospital. Nursing documentation for Resident 23 dated April 14, 2025, at 5:53 PM revealed the resident returned to the nursing facility. Clinical record review for Resident 50 revealed	F 0628		

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F 0628 SS=C	Continued from page 23 nursing documentation dated May 6, 2025, at 2:07 PM that noted the resident was sent to the hospital for a change in condition. Nursing documentation for Resident 50 dated May 6, 2025, at 10:45 PM revealed that the resident was admitted to the hospital. Nursing documentation for Resident 50 dated May 12, 2025, at 4:18 PM revealed that the resident returned to the facility and was transferred back to the hospital for re-evaluation. An interview with the Nursing Home Administrator on July 2, 2025, at 3:16 PM revealed the ombudsman was not notified of the transfers to the hospital for Residents 23 and 50. Clinical record review for Resident 55 revealed that they were transferred to the hospital on November 18, 2024, after there was a change in their condition. There was no documentation that the facility provided written notification to the State	F 0628		

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F 0628 SS=C	Continued from page 24 Ombudsman as required regarding the transfer. Clinical record review for Resident 64 revealed that they were transferred to the hospital on June 21, 2025, after there was a change in their condition. There was no documentation that the facility provided written notification to the State Ombudsman as required regarding the transfer. Clinical record review for Resident 26 revealed the resident was sent to the hospital on April 24, 2025, for a change in condition and admitted. Clinical record review for Resident 28 revealed the resident was sent to the hospital on May 26, 2025, for a change in condition and admitted. Clinical record review for Resident 57 revealed the resident was sent to the hospital on January 30, 2025, for a change in condition and admitted. There was no evidence facility staff notified the States Ombudsman of the transfers out of the facility	F 0628		

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F 0628 SS=C	Continued from page 25 for Residents 25, 26, and 57. Interview the Nursing Home Administrator on July 2, 2025, at 2:08 PM revealed facility staff had not been notifying the States Ombudsman of transfers to the hospital as required. Clinical record review for Resident 13 revealed a nursing note dated June 6, 2025, at 5:35 PM indicating the resident was transferred to the hospital. There was no documentation that the facility provided the required written notification to the State Ombudsman regarding the transfer. Clinical record review for Resident 66 revealed the facility transferred him to the hospital on March 21, 2025, March 31, 2025, and April 11, 2025. There was no documentation that the facility provided the required written notification to the State Ombudsman regarding the transfer. The surveyor reviewed the above information with the Nursing Home Administrator on July 2, 2025, at	F 0628		

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F 0628 SS=C	Continued from page 26 2:50 PM. The Administrator stated they do not send notifications for hospital admissions. 28 Pa. Code 201.14(a) Responsibility of license 28 Pa. Code 201.29(a) Resident rights	F 0628		
F 0684 SS=E		F 0684		

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F 0684 SS=E	Continued from page 27 483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by:	F 0684	1. Resident 67 has discharged from the facility. 2. An audit of last 14 days was completed of any other Aspira Catheter Drains or chest tubes in the facility and that LPN's were not providing valve changes or dressing changes. 3. All LPN staff will be educated and competency will be completed related to Chest Tubes and Chest Tube Management. All licensed staff will be educated on proper documentation in the electronic medical record. 4. Audits will be conducted by the DON/Designee of any resident with a chest tube to ensure all physician orders related to same are being followed for dressing changes and documentation, daily 4x a week, weekly for 4 weeks and monthly x2. Results of the audits will be presented at the QAPI committee to ensure ongoing compliance.	Completion Date: **08/12/2025** Status: **APPROVED** Date: **07/23/2025**

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F 0684 SS=E	Continued from page 28 Based on clinical record review and staff interview, it was determined that the facility failed to provide the highest practicable care regarding physician ordered interventions and treatments for one of 19 residents (Resident 67). Findings include: Clinical record review for Resident 67 revealed physician orders for the following: Ordered on May 29, 2025, and discontinued on June 22, 2025, for only registered nursing (RN) staff to drain the Aspira catheter (a chest tube/catheter inserted into the lung area/cavity to drain excessive fluids) every other day on day shift. RN staff were not to exceed 1000 ml (milliliters) of fluid each time. Staff were to document the output, color, and character of drainage in a progress note, Ordered on May 29, 2025, and discontinued on June 22, 2025, for only RN staff to change the Aspira chest tube/catheter drain dressing every	F 0684		

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F 0684 SS=E	Continued from page 29 other day on day shift. Ordered on June 5, 2025, and discontinued on June 22, 2025, for only RN staff to change the Aspira chest tube/catheter drain connecting valve weekly on day shift. Clinical record review for Resident 67 revealed there was no documentation that RN staff drained the Aspira catheter on June 2, 4, 8, 12, 16, and 18, 2025. Upon further review, licensed practical nursing (LPN) staff documented completion of draining the Aspira catheter on June 10 and 14, 2025. There was no documentation that RN staff changed the Aspira catheter dressing on June 2, 4, 8, 12, 16, and 18, 2025. Upon further review, LPN staff documented completion of the Aspira catheter dressing on June 10 and 14, 2025. There was no documentation that RN staff changed the Aspira catheter connecting valve on June 12 and	F 0684		

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F 0684 SS=E	Continued from page 30 19, 2025. Upon further review, LPN staff documented completion of the Aspira catheter connecting valve change on June 5, 2025. Review of staffing education for Aspira catheter drains revealed that the facility educated RN staff on May 29, 2025. There was no documentation that the facility educated LPN staff on Resident 67's Aspira catheter. The above information was reviewed during an interview on July 3, 2025, at 9:50 AM with the Director of Nursing. 483.25 Quality of Care Previously cited 6/14/24 28 Pa. Code 211.10(c) Resident care policies 28 Pa. Code 211.12(c)(d)(1)(3)(5) Nursing Services	F 0684		

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F 0689 SS=D	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by:	F 0689	1. Resident 7 and 46 immediately had chair alarm added the day of the survey. 2. A whole house audit was completed on all residents who are ordered/CP'ed to have a chair alarm to ensure placement in wheelchair, and that chair alarm is listed in Kardex. 3. All residents who have an order/or CP'ed as a fall intervention will have a chair alarm in place when in wheelchair. All nursing staff will be educated to ensure chair alarm is in place when resident is in chair. All CNA's will be educated to check Kardex if Chair Alarm is needed for safety. 4. Random resident audits will be conducted of residents requiring a chair alarm, daily 4x a week, weekly for 4 weeks and monthly x2 by the Administrator/designee to chair alarm is in place and in working order. Results of the audits will be presented at the QAPI committee to ensure ongoing compliance.	Completion Date: **08/12/2025** Status: **APPROVED** Date: **07/23/2025**

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F 0689 SS=D	Continued from page 32 Based on observation, clinical record review, and staff interview, it was determined that the facility failed to implement interventions related to fall prevention for two of six residents reviewed (Residents 7 and 46). Findings include: Clinical record review for Resident 7 revealed a diagnosis list that included the following: unsteadiness on feet, dementia (a group of symptoms related to loss of memory, judgment, language, complex motor skills, and other intellectual function, caused by the permanent damage or death of the brain's nerve cells, or neurons), abnormalities of gait and mobility, and muscle weakness. Clinical record review for Resident 7 revealed a quarterly Minimum Data Set Assessment (MDS, an assessment completed at specific intervals to determine care needs) dated May 6, 2025, that noted facility staff assessed the resident as having a BIMS (Brief Interview for Mental Status) of 4,	F 0689		

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F 0689 SS=D	Continued from page 33 which indicated severe cognitive impairment. Current physician orders for Resident 7 dated April 28, 2025, at 10:30 PM indicated the resident was to have a bed/chair alarm and check placement and function every shift. Review of Resident 7's care plan revealed that the resident is at risk for falls related to limited mobility and dementia. An intervention included a chair alarm. Nursing documentation dated May 1, 2025, at 10:16 AM revealed an interdisciplinary note for a fall risk meeting that noted Resident 7 had a fall on April 28, 2025. The root cause was noted as self-transferring from the wheelchair to the bed. An intervention was to place a chair alarm. Observation of Resident 7 on July 1, 2025, at 1:58 PM and 3:20 PM revealed the resident was in a wheelchair. Continued observation revealed the resident was able to self-propel the wheelchair and	F 0689		

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F 0689 SS=D	Continued from page 34 was mobile in the hallway and his room. There was no observed chair alarm on the wheelchair. The alarm was observed hanging on the resident's dresser next to the bed. Interview with Employee 4, licensed practical nurse, on July 1, 2025, at 3:29 PM revealed that Resident 7 should have a chair alarm on his wheelchair. Employee 4 proceeded to take the alarm hanging on the resident's dresser, power it on, and placed it on Resident 7's wheelchair. The above information for Resident 7 was reviewed in a meeting with the Nursing Home Administrator and Director of Nursing on July 2, 2025, at 11:30 AM. Clinical record review for Resident 46 revealed a physician's order dated March 18, 2025, for staff to implement a chair alarm (a pressure sensitive device that alarms when a person moves and releases the pressure on the alarm) and to check for function and placement every shift.	F 0689		

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F 0689 SS=D	Continued from page 35 Observation of Resident 46 on the following dates and times revealed that they were seated in a wheelchair but did not have a chair alarm per their physician order: July 1, 2025, 11:14 AM July 2, 2025, 8:52 AM, 9:20 AM, 9:25AM, and 12:06 PM Concurrent interview with Employee 5, licensed practical nurse, during the July 2, 2025, 9:25 AM observation confirmed that Resident 46 did not have a chair alarm while seated in their wheelchair. The surveyor reviewed this information during an interview with the Nursing Home Administrator and Director of Nursing Home on July 2, 2025, at 11:35 AM 483.25(d)(1)(2) Free of Accident Hazards/supervision/devices Previously cited deficiency 5/8/25	F 0689		

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F 0689 SS=D	Continued from page 36 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services	F 0689		
F 0801 SS=F	483.60(a)(1)(2) Qualified Dietary Staff §483.60(a) Staffing The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71. This includes: §483.60(a)(1) A qualified dietitian or other clinically qualified nutrition professional either full-time, part-time, or on a consultant basis. A qualified dietitian or other clinically qualified nutrition professional is one who- (i) Holds a bachelor's or higher degree granted by a regionally accredited college or university in the United States (or an equivalent foreign degree) with completion of the academic requirements of a program in nutrition or dietetics accredited by an appropriate national accreditation organization recognized for this purpose. (ii) Has completed at least 900 hours of supervised dietetics practice under the supervision of a registered dietitian or nutrition professional. (iii) Is licensed or certified as a dietitian or nutrition professional by the State in which the services are	F 0801	1. Facility is unable to retroactively correct past deficiency. 2. Employee #1 has been enrolled in the "ServeSafe for Managers" course. 3. Administrator will be educated on Qualified Dietary Staff Requirement. 4. Administrator/Designee will audit Employee #1's progress in "ServeSafe for Managers" course weekly x4 weeks to ensure timely completion. Results will be forwarded to QA committee.	Completion Date: **08/12/2025** Status: **APPROVED** Date: **07/23/2025**

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F 0801 SS=F	Continued from page 37 performed. In a State that does not provide for licensure or certification, the individual will be deemed to have met this requirement if he or she is recognized as a "registered dietitian" by the Commission on Dietetic Registration or its successor organization, or meets the requirements of paragraphs (a)(1)(i) and (ii) of this section. (iv) For dietitians hired or contracted with prior to November 28, 2016, meets these requirements no later than 5 years after November 28, 2016 or as required by state law. §483.60(a)(2) If a qualified dietitian or other clinically qualified nutrition professional is not employed full-time, the facility must designate a person to serve as the director of food and nutrition services. (i) The director of food and nutrition services must at a minimum meet one of the following qualifications- (A) A certified dietary manager; or (B) A certified food service manager; or (C) Has similar national certification for food service management and safety from a national certifying body; or D) Has an associate's or higher degree in food service management or in hospitality, if the course study includes food service or restaurant management, from an accredited institution of higher learning; or (E) Has 2 or more years of experience in the position of director of food and nutrition services in a nursing facility setting and has completed a course of study in food safety and management, by no later than October 1, 2023, that includes topics integral to managing dietary operations including, but not limited to, foodborne illness, sanitation	F 0801		

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F 0801 SS=F	Continued from page 38 procedures, and food purchasing/receiving; and (ii) In States that have established standards for food service managers or dietary managers, meets State requirements for food service managers or dietary managers, and (iii) Receives frequently scheduled consultations from a qualified dietitian or other clinically qualified nutrition professional. This REQUIREMENT is not met as evidenced by:	F 0801		

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F 0801 SS=F	Continued from page 39 Based on staff interview, it was determined that the facility failed to employ a full-time qualified director of food and nutrition services in the absence of a full-time qualified dietitian. Findings include: During an interview on July 1, 2025, at 10:10 AM, Employee 2, registered dietitian indicated she was only employed at the facility three days a week (not full-time). Concurrently, Employee 1, dietary manager, indicated she was not a certified dietary manager, certified food service manager, did not have a national certification for food service management and safety, and did not hold a degree in food service management. In a follow up interview on July 1, 2025, at 12:00 PM the Nursing Home Administrator confirmed the facility did not employe a full-time qualified dietitian or qualified director of food and nutrition services. Cross Refer F812	F 0801		

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F 0801 SS=F	Continued from page 40 28 Pa. Code 201.18(b)(1)(3) Management	F 0801		
F 0812 SS=F		F 0812		

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F 0812 SS=F	Continued from page 41 483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by:	F 0812	1. All areas identified during survey regarding cleanliness were corrected. The uncovered cups of milk in the cooler were discarded at the time of the survey. The shelves have been replaced with a non-porous shelf. The lower shelves that were using wood was removed and replaced with a non-porous material. The floors of both panty's were cleaned. 2. Food Service Director and Administrator will conduct an audit of general cleanliness standards of kitchen to ensure no other cleanliness issues are present. 3. Food Service Director and dietary staff will be educated on general cleanliness standards of the kitchen. Housekeeping, Dietary Staff, and Nursing will be educated on cleanliness of the pantry's. Maintenance will be educated on cleaning the dust in the ceiling and kitchen ceilings will be added to a cleaning schedule. Daily cleaning checklists for each dietary shift will be updated, and	Completion Date: 08/12/2025 Status: APPROVED Date: 07/23/2025

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F 0812 SS=F	Continued from page 42	F 0812	dietary supervisor cleaning list was updated and will be signed off at the completion of shift. Weekly cleaning checklists will be implemented and signed off by FSD and submitted to the Admin. 4. Nursing home administrator/designee will conduct random audits of kitchen areas daily x4 days a week for two weeks and then weekly times two months. Results will be reviewed during the monthly QAPI meeting to ensure ongoing compliance.	

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F 0812 SS=F	Continued from page 43 Based on observation and staff interview, it was determined that the facility failed to maintain food service equipment in accordance with professional standards for food service safety and store food in a sanitary manner in the facility's main kitchen and on two of two nursing units (Sage and Ivy). Findings include: An observation in the facility's main kitchen on July 1, 2025, at 10:10 AM with Employee 1, dietary manager, revealed the following: The interior of the water wells of the steam table were observed on (hot), with water in the compartments (wells that hold water produce the steam to keep pans of food placed above the water hot). Employee 1 indicated breakfast had been served and the breakfast pans had already been removed from the steam table. The interior base of the steam table compartments was coated in a buildup of brown film. A significant amount of food debris was also observed floating in the water of the	F 0812		

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F 0812 SS=F	Continued from page 44 compartments including vegetables, potatoes, and other food debris that was not served at breakfast. A two-door cooler was observed with three plastic bins on the shelf in the cooler. The bins were filled cups that had milk poured in them. The cups of milk were not covered or dated as to when they were placed there or when they needed used by. The ceiling over the dish room area contained multiple areas of rust-colored spots. A pipe extending through the dish washing area near the ceiling was covered in visible dust. The light covers over the area were dirty with blackened areas and dried food splatter. The walk-in freezer contained large chunks of ice on the floor behind the condenser area. The lower freezer shelves where food products were stored were lined with a porous wood covering presenting a risk for harboring bacteria/organisms. The dry storage area contained multiple wire rack	F 0812		

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F 0812 SS=F	Continued from page 45 shelving units holding food products. The lower shelves throughout the dry storage room were also lined with the same porous wood coverings. Multiple areas of the wood shelf coverings were observed with dried liquid stains in the wood. A concurrent observation of the Sage nursing unit pantry, which extends from the main kitchen to the Sage hallway was observed with a buildup of dust, debris, and dried spills on the flooring of the pantry. A large round garbage can in the area had dried food splatter in several spots on the exterior of the can. The wall behind and beside the garbage can was covered in dried food splatter from three feet up the wall to the floor. The refrigerator in the Sage pantry was soiled on the interior base and the lower vent unit at the front of the refrigerator was soiled and dusty. An observation of the Ivy nursing unit pantry on July 1, 2025, at 10:30 AM revealed the flooring in the area was blackened and dirty. The interior of a single door cooler in the pantry was soiled with	F 0812		

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F 0812 SS=F	Continued from page 46 dried purple liquid on the interior base of the cooler. The above findings in the main kitchen were reviewed with the Nursing Home Administrator and Director of Nursing on May 2, 2025, at 12:00 PM. 483.60(i)(2) Store, prepare, food safe and sanitary Previously cited 6/14/24 28 Pa. Code 201.14 (a) Responsibility of Licensee	F 0812		
F 0880 SS=D		F 0880		

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F 0880 SS=D	Continued from page 47 483.80(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	1. Facility is unable to retroactively correct staff member entering room to give high-contact care with incorrect PPE. 2. An audit of all residents on EBP was completed to ensure proper signage to include proper PPE required. 3. All nursing staff will be educated on EBP, including what PPE is required and when it is required. 4. Administrator or designee will complete a random audit of residents on EBP 4x a week for 4 weeks and weekly for 2 months to ensure proper PPE is being used and at the correct times. Results will be reviewed by QAPI committee for further action planning as necessary.	Completion Date: **08/12/2025** Status: **APPROVED** Date: **07/23/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396137	A. BLDG: 00 B. WING:	07/03/2025

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F 0880 SS=D	Continued from page 48 (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by:	F 0880		

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F 0880 SS=D	Continued from page 49	F 0880		

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F 0880 SS=D	Continued from page 50 Based on observation, clinical record review, and staff interview, it was determined that the facility failed to implement appropriate Enhanced Barrier Precautions (EBP) for one of 24 residents reviewed (Resident 276). Findings include: Review of the memo entitled "Enhanced Barrier Precautions (EBP, gown and glove use) in Nursing Homes to Prevent the Spread of Multi-drug Resistant Organisms" released by the Center for Medicaid and Medicare Services (CMS) on March 20, 2024, with an implementation date of April 1, 2024, revealed that nursing care facilities are to use EBP for residents with chronic wounds or indwelling medical devices during high-contact resident care activities regardless of their multidrug-resistant organism status. High-contact activity would include dressing, transferring, changing linens, providing hygiene, changing briefs, wound care, device care, etc.	F 0880		

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F 0880 SS=D	Continued from page 51 During an observation and interview with Resident 276 on July 1, 2025, at 3:07 PM an enhanced barrier sign was observed outside Resident 276's door. Resident 276 indicated that he had a urinary foley catheter (a medical device consisting of tubing inserted into the urethra to collect urine) and a chest tube (a medical device consisting of a tube inserted through the chest cavity wall to collect drainage). Resident 276's clinical record revealed an active physician's order dated June 27, 2025, that reads "Enhanced barrier precautions for indwelling foley and chest tube". An observation of a chest tube dressing change on Resident 276 on July 2, 2025, at 11:16 AM revealed Employee 3, Registered Nurse, entered Resident 276's room, donned gloves, removed the dressing, and cleansed around the chest tube insertion site, changed gloves, and applied a new dressing. Employee 3 did not don a gown during this	F 0880		

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F 0880 SS=D	Continued from page 52 high-contact procedure, as required for EBP. The surveyor reviewed the above information with the Nursing Home Administrator and the Director of Nursing on July 2, 2025, at 12:29PM. 483.80(a)(1)(2)(4)(e)(f) Infection Prevention and Control 28 Pa. Code 211.12(d)(1) Nursing services	F 0880		

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P 1020	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	1. Facility is unable to retroactively correct deficiency for past Act 52 meetings. 2. An employee of the Pharmacy and a Representative from the Labortory have been invited to the next QA/Act 52 meeting. 3. All attempts will be made to ensure all appropriate members are present and will facilitate via phone conference if necessary. The Administrator and DON will be educated on which members of the multidisciplinary committee need to be present for QA/Act 52 meetings. 4. Monthly sign-in sheets for QA/Act 52 will be reviewed to ensure all appropriate members of QA/Act 52 meeting was present monthly and results will be forwarded to QA meeting to ensure ongoing compliance.	Completion Date: **08/12/2025** Status: **APPROVED** Date: **07/23/2025**

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

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P 1020	Continued from page 1 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		

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P 1020	Continued from page 2 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 June 14, 2024) during an interview with the Nursing Home Administrator and the Director of Nursing on July 1, 2025, at 10:27 AM. The facility provided documentation titled "QAPI (Quality Assurance and Performance Improvement) Attendance." An interview with the Nursing Home Administrator	P 1020		

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P 1020	Continued from page 3 on July 3, 2025, at 9:08 AM revealed that the facility's infection control meetings are held during the QAPI meetings on a quarterly basis or more frequently if needed. Review of the facility provided attendance records dated June 20, 2024; September 26, 2024; October 24, 2024; December 17, 2024; March 18, 2025; and May 7, 2025, revealed that there was no evidence that the facility included any pharmacy or lab personnel. The documentation had no signatures to attest that these personnel attended any of the meetings. The above findings were reviewed with the Nursing Home Administrator during an interview on July 3, 2025, at 11:26 AM.	P 1020		

Certified End Page

ATHENS NURSING AND REHABILITATION CENTER

STATE LICENSE NUMBER: 24210201

SURVEY EXIT DATE: 07/03/2025

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