STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395699	A. Building B. Wing	09/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sweden Valley Manor	1028 East Second Street Coudersport, PA 16915

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. 38839 Based on observations, clinical record review, and resident and staff interview, it was determined that the facility failed to administer medication per physician's orders for one of 24 residents reviewed (Resident 48). Findings include: Observation of Resident 48 on September 17, 2024, at 2:00 PM revealed the resident was lying in bed watching television. A medicine cup with pills in it was observed on the resident's bedside table beside the bed. As the surveyor began speaking with Resident 48, the resident grabbed the medicine cup and proceeded to dump the cup of pills in his mouth and then his water cup before the resident responded to the surveyor. The resident indicated he had just taken his pills. No staff were present in the room or hall near the resident's room. Clinical record review for Resident 48 revealed a physician's order dated April 9, 2023, indicating the resident may not self-administer, due to no request. Review of Resident 48's medication administration record for September 17, 2024, revealed the resident was documented as being administered Propranolol (a medication used to treat heart problems), Sinemet (a medication used to treat Parkinson's disease), and Seroquel (an antipsychotic medication), at 1:25 PM. In an interview the Nursing Home Administrator and Director of Nursing on September 18, 2024, at 2:10 PM it was confirmed Resident 48 should not have had medications left in his room for self-administration. 28 Pa. Code 211.12(d)(1)(5) Nursing services

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 44738 Based on observations and family interview, it was determined that the facility failed to provide a clean, comfortable, homelike environment on one of four nursing units (C Nursing Unit; Residents 7 and 55). Findings include: Observation of the C Unit shower room on September 18, 2024, at 9:25 AM revealed the external sealing located on the floor around the base of the commode was a brownish color and peeling away from the commode in some areas. There was also a significant accumulation of dust on a vent located on the ceiling. An interview with Resident 7's family on September 20, 2024, at 9:00 AM revealed concerns related to the cleanliness of the heating unit on the wall in Resident 7's room. Observation of the heating unit on the wall in Resident 7's room on September 20, 2024, at 9:41 AM revealed an extensive build-up of dust on vents of the unit. There was also an accumulation of debris under the unit. Observation of the heating unit on the wall of Resident 55's room on September 20, 2024, at 9:44 AM revealed an extensive build-up of dust on the vents of the unit. There was also an accumulation of debris under the unit. The above information was reviewed in a meeting with the Nursing Home Administrator and Director of Nursing on September 20, 2024, at 11:57 AM. 483.10(i)(1)-(7) Safe/clean/comfortable/homelike Environment Previously cited deficiency 10/20/23 28 Pa. Code 201.18(b)(3)(e)(2.1) Management

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 19719 Based on clinical record review and staff interview, it was determined that the facility failed to ensure complete and accurate Minimum Data Set (MDS) assessments for one of 20 residents reviewed (Resident 60). Findings include: Resident 60 was admitted to the facility on [DATE], with a diagnosis of pneumonia from the hospital setting. Review of Resident 60's clinical record revealed a Minimum Data Set Assessment (MDS, a form completed at specific intervals to determine care needs) dated August 17, 2024, that indicated the facility assessed him as still having an active pneumonia infection. There was no documented evidence in Resident 60's clinical record to indicate that he continued to have an active pneumonia infection since April 27, 2024. Interview with the Director of Nursing on September 19, 2024, at 9:40 AM confirmed that Resident 60's pneumonia diagnosis was coded in error on the MDS dated [DATE]. 28 Pa. Code 211.5(f)(ix) Medical records 28 Pa. Code 211.12(d)(1)(5) Nursing services

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. 36798 Based on clinical record review and staff interview, it was determined that the facility failed to provide care or services to maintain a resident's ambulation status for one of two residents reviewed for ambulation concerns (Resident 15). Findings include: Clinical record review for Resident 15 revealed that she was on a nursing rehabilitation program for ambulation. The program was ordered on November 7, 2023. The program indicated that she was to be ambulated with the assistance of one staff and a wheeled walker. A therapy recommendation form dated October 31, 2023, confirmed the above noted program was a therapy recommended program. Further clinical record review for Resident 15 revealed that there was no documented evidence that the ambulation program was being completed. The Director of Nursing and the Nursing Home Administrator were made aware of concerns related to Resident 15's ambulation program and confirmed the above noted findings on September 19, 2024, at 2:12 PM. The facility failed to provide restorative/rehabilitation services in order to maintain Resident 15's ambulation abilities. 28 Pa. Code 211.12(d)(1)(5) Nursing services

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. 44738 Based on observation, clinical record review, and resident and staff interview, it was determined that the facility failed to obtain proper treatment to maintain vision for one of two residents reviewed for vision concerns (Resident 1). Findings include: An interview with Resident 1 on September 17, 2024, at 11:37 AM revealed she feels her vision has gotten worse and reported a history of macular degeneration. The resident was unsure when her last vision appointment was. The resident was admitted in 2019. Clinical record review for Resident 1 revealed a diagnosis list that included diabetes mellitus (a disorder of the metabolism that impacts insulin production and causes high blood sugar levels). There was no listed diagnosis for macular degeneration noted in the electronic health record diagnoses list. A review of the current physician orders revealed an order dated February 2, 2020, that indicated that Resident 1 may be seen by the audiologist, dentist, podiatrist, optometrist, and ophthalmologist. A quarterly Minimum Data Set Assessment (MDS, an assessment completed at specific intervals to determine care needs) dated August 21, 2024, noted facility staff assessed the resident as having a BIMS (Brief Interview for Mental Status) of 6, which indicated cognitive impairment. The MDS noted facility staff further assessed the resident as being vision impaired. An MDS progress note dated August 3, 2023, at 4:27 PM revealed that Resident 1 can make needs known and answers questions appropriately. The note further revealed that, Resident has macular degeneration so some trouble with vision. A current care plan for Resident 1 revealed the resident has impaired visual function related to diabetes mellitus. Further clinical record review for Resident 1 revealed no evidence that the facility offered the resident or the resident's responsible party vision services (such as an eye exam). A request was made by the surveyor during a meeting with the Nursing Home Administrator and Director of Nursing on September 18, 2024, at 1:45 PM and September 19, 2024, at 2:27 PM to provide any further documentation for Resident 1 that the facility offered an eye appointment to the resident or the resident's responsible party, the resident/responsible party refused, or any type of related documentation since admission to the facility. A meeting with the Nursing Home Administrator and Director of Nursing on September 20, 2024, at 11:57 AM revealed the facility was unable to find any documentation from a previous appointment or that Resident 1 or the resident's responsible party was offered eye services by the facility. (continued on next page)

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	28 Pa. Code 211.12(d)(1)(3)(5) Nursing services

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate foot care. 19719 Based on observation, clinical record review, and staff and resident interview, it was determined that the facility failed to provide foot care and treatment to avoid medical complications for one of one resident reviewed (Resident 49). Findings include: Interview with Resident 49 on September 17, 2024, at 11:30 AM revealed that he has not seen a podiatrist for his left foot. Observation of Resident 49's left foot during the interview revealed that his toenails were elongated. The nail on the first and second toes were thick and yellow, and so long that they were beginning to curve. Review of Resident 49's clinical record revealed that the facility admitted him on March 30, 2024, with a diagnosis of diabetes. There was no documented evidence in Resident 49's clinical record to indicate the facility initiated diabetic foot care to care for his nails and avoid medical complications, until after this surveyor made observations and spoke with Resident 49 about his foot. Interview with the Director of Nursing on September 19, 2024, at 11:49 AM confirmed the above findings for Resident 49. 28 Pa. Code 211.12(d)(3)(5) Nursing services

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 19719 Based on clinical record review and staff interview, it was determined that the facility failed to implement a restorative nursing program as recommended by therapy to maintain range of motion for four of five residents reviewed (Residents 22, 15, 47, and 64). Findings include: Review of Resident 22's clinical record revealed a Minimum Data Set Assessment (MDS, an assessment completed at specific intervals to determine care needs) dated August 2, 2024, that indicated the facility assessed Resident 22 as having range of motion (ROM) limitations to both sides of her lower extremities. A previous MDS assessment dated [DATE], indicated that the facility assessed Resident 22 as having no ROM limitations to her lower extremities. A physical therapy form entitled Restorative Nursing Program Plan, dated July 12, 2024, indicates that physical therapy implemented a restorative program for nursing staff to complete a lower extremity active range of motion program for Resident 22. There was no documented evidence in Resident 22's clinical record to indicate that the therapy recommended restorative range of motion program was implemented. Interview with the Director of Nursing on September 19, 2024, at 2:04 PM confirmed the above findings for Resident 22. Clinical record review for Resident 15 revealed a plan of care that indicated she was to receive a nursing rehab program that consisted of active range of motion (AROM, exercise using your own muscle strength to move a body part through normal motion) to her bilateral lower extremities. There was no documented evidence in Resident 15's clinical record to indicate that the staff were completing the program as noted in her plan of care. Clinical record review for Resident 47 revealed a plan of care that was initiated on October 12, 2023, that indicated he was to have gentle AROM to his bilateral lower extremities 2-3 sets of 10 repetitions 3 times a week. He also had a recommendation from therapy dated October 5, 2023, that indicated he was to have PROM (Passive Range of Motion, movement of a joint performed by an outside force such as a nurse aide or therapist) to his bilateral upper extremities. The therapy recommendation indicated that this was ordered on October 13, 2023. Further clinical record review revealed that there was no documented evidence in Resident 47's clinical record that indicated he was receiving AROM to his lower extremities or PROM to his upper extremities. Interview with the Director of Nursing and Nursing Home Administrator on September 18, 2024, at 2:10 PM and again on September 19, 2024, at 2:12 PM confirmed the above noted findings related to range of motion programs for Residents 15 and 47. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Clinical record review for Resident 64 revealed a quarterly MDS dated [DATE], that indicated facility staff assessed the resident as having a BIMS score of 3 that indicated a severe cognitive impairment level. A physical therapy form for Resident 64 titled Restorative Nursing Program Plan, dated May 11, 2024, indicated that therapy implemented a restorative program for nursing staff to complete an upper extremity (UE) active ROM program as tolerated. An interview with Employee 4, Director of Therapy, on September 20, 2024, at 10:05 AM revealed the above program for Resident 64 was implemented upon discharge from occupational therapy. A review of Resident 64's task list revealed that Resident 64 was to complete an upper extremity active ROM program as tolerated. There was no documented evidence in Resident 64's clinical record to indicate that staff were completing the ROM program, or the resident was refusing to participate. The above information for Resident 64 was reviewed in a meeting with the Nursing Home Administrator and Director of Nursing on September 20, 2024, at 11:57 AM. S483.25(c) Mobility Previously cited 10/20/23 28 Pa. Code 211.12 (d)(1)(5) Nursing services

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate pain management for a resident who requires such services. 38839 Based on clinical record review and resident and staff interview, it was determined that the facility failed to ensure that pain management was provided that was consistent with professional standards of practice, for one of one resident reviewed (Resident 48). Findings include: In an interview with Resident 48 on September 17, 2024, at 2:00 PM he indicated that he had been having pain in his tail bone area from a recent fall that still hurts. Clinical record review for Resident 48 revealed a physician's order dated July 11, 2022, for the resident to have Acetaminophen (a medication used to treat mild pain) 325 milligrams (mg), two tablets every six hours as needed for a pain level 1-5. Resident 48 had an additional order for Tramadol HCL (a medication used to treat moderate to severe pain) 75 mg every six hours as needed for a pain level of 6-10. A review of Resident 48's medication administration record (MAR) for August 2024, revealed Resident 48 was administered the Tramadol on August 3, 9, 26, and 30 for a pain level of 5, and on August 29, for a pain level documented as 0. There was no evidence Resident 38 was administered the as needed Acetaminophen at all on August 3, 9, 26, or 30, 2024. A review of Resident 48's MAR for September 2024, revealed Resident 48 was administered Tramadol on September 6, for a pain level of 4, and September 7, 8, 9, 16, and 18, for a pain level of 5. There was no evidence Resident 48 was administered any as needed acetaminophen for September as of September 18, 2024. Facility staff did not administer Resident 48's pain medication per the physician ordered pain scale for August and September 2024, as noted above. The above information regarding Resident 48 was reviewed with the Nursing Home Administrator and Director of Nursing on September 19, 2024, at 2:10 PM. 28 Pa Code 211.10(c) Resident care policies 28 Pa Code 211.12(d)(1) Nursing services

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 19719 Based on observation, clinical record review, review of select manufacture's guidelines, and staff interview, it was determined that the facility failed to ensure a medication error rate below five percent (Resident 11). Findings include: The facility's medication error rate was 7.69 percent based on 26 medication opportunities with two medication errors. Observation of a medication administration pass on September 17, 2024, at 10:20 AM revealed Employee 1, licensed practical nurse, preparing to administer Potassium Chloride (used as a supplement for heart, nerve, and muscle health) 20 MEq (milliequivalent) ER (extended release) and Metoprolol (treats hypertension) 100 mg (milligrams) ER. Employee 1 proceeded to crush both the Potassium Chloride and the Metoprolol extended-release tablets prior to administering them to Resident 11. According to The Institute for Safe Medication Practices, do not crush list, last updated in 2016, revealed that both the Potassium Chloride ER and the Metoprolol ER should not be crushed. Both medications are indicated as slow release. Interview with Employee 1 on September 17, 2024, at 10:30 AM confirmed the above findings for Resident 11. Interview with the Director of Nursing on September 19, 2024, at 2:00 PM also confirmed that Employee 1 should not have crushed the medications administered as noted above to Resident 11. 28 Pa. Code 211.10(a) Resident care policies 28 Pa. Code 211.12(d)(1)(5) Nursing services

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. 36798 Based on clinical record review and resident and staff interview, it was determined that the facility failed to ensure timely dental services for one of one resident reviewed for dental concerns (Resident 29). Findings include: Interview with Resident 29 on September 17, 2024, at 2:08 PM revealed that she was concerned about her top denture that she has never received. She indicated that she was to receive them today, but the dentist indicated that she was not on the list. She said that he did not provide any other information and that he then left the building. She said she has been waiting on this denture since at least June 2024, but that the whole process started much earlier. Clinical record review for Resident 29 revealed a dental consult summary dated August 9, 2023, revealed that dental impressions for upper denture were made. A dental consult summary dated October 17, 2023, revealed that Resident 29 needed to continue treatment with the dentist for denture care. A dental consult summary dated November 10, 2023, revealed that Resident 29's bite registration (taking an impression of her teeth) was completed for her upper denture. A dental consult summary dated December 12, 2023, revealed that the dentist would continue the denture process. A dental consult summary dated February 12, 2024, revealed that the resident was not seen due to being sick with the flu. A dental consult summary dated March 12, 2024, revealed that the dentist tried the new upper denture with Resident 29 and changes needed to be made. The note indicated that the denture would be delivered on the next visit. Further clinical record review revealed no further dental consult visit summary for Resident 29. The Director of Nursing and the Nursing Home Administrator were made aware of the concerns with Resident 29's dentures on September 18, 2024, at 2:08 PM. The facility provided the surveyor with a copy of an email that was between the facility and the consulting dental clinic dated September 17, 2024, at 9:29 AM. The email was initiated from the facility. The email indicated that Resident 29 wanted to be seen by the dental hygienist. The response from the consulting dental clinic revealed that Resident 29's family has declined dental service and that the clinic even had to stop the denture process because the power of attorney declined. Review of Resident 29's clinical record revealed a current order that indicated she was capable of understanding her rights and responsibilities. (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review Resident 29's last MDS (Minimum Data Set, an assessment completed at intervals by the facility to determine care needs of the resident) dated June 26, 2024, indicated that she had 15 BIMs (Brief Interview for Mental Status) indicating she is cognitively intact. Review of Resident 29's POA (Power of Attorney) document dated August 11, 2023, indicated that it is only effective if a licensed medical doctor deemed her to be incapable. Interview with Resident 29 on September 20, 2024, at 11:35 AM revealed that she was unaware that the denture process was stopped by her POA. She indicated that someone should have talked to her because she has been waiting for her dentures and still wants them. The Nursing Home Administrator and Director of Nursing were made aware of the above noted information related to Resident 29's dental services in a meeting on September 19, 2024, at 2:12 PM. The facility failed to ensure timely dental services for Resident 29. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services 28 Pa. Code 211.15. Dental services

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38839 Based on observation and staff interview, it was determined the facility failed to store food and maintain food service equipment in a safe and sanitary manner and prevent the potential for food contamination in the facility's main kitchen. Findings include: An observation of the facility's main kitchen on September 17, 2024, at 11:50 AM with Employee 2, corporate dietitian, revealed the following: The coffee station area contained dried brown liquid spills and dried food splatter on the wall behind the coffee machine, which extended down the wall to the floor area observed under the counter space. The lower shelf of the table area where the coffee dispenser was located contained dust and debris and dried liquid spills, along with a plastic dish rack filled with clear plastic jugs, which the interiors were significantly stained brown making them opaque. A plastic tray beside the rack of pitchers also contained plastic gallon jugs with interior brown staining sitting on the tray, which had dried food debris and dried liquid spills. A carboard box of coffee filters was also sitting on the lower shelf. The box was soiled with dried liquid spills. A small foot pedal trash can under the coffee area had dried debris and spills and dried brown liquid splatter covering the exterior. A carboard box of film wrap was observed lying on top of stacks of dish racks with cups/bowls in them. The exterior box of the film wrap was stained and dirty. Multiple bag in box juices were observed on a rack, with tubing from each box connected to a fountain dispenser above them on a counter. The plastic connecter to the box and the tubing connecting the box to the dispenser from each box was sticky, covered in dust, and some dried juice product was observed on the plastic connection pieces. An air compressor sitting on the floor by the bag in box juice rack was covered in thick dust. A two-door cooler in the tray line area had a broken door rubber gasket. Pieces of the gasket were observed hanging out of the closed cooler door. A white oven mitt was observed sitting on top of a plate warmer positioned by the tray assembly line. The oven mitt was significantly blackened and contained dried food. Four additional oven mitts were significantly stained black and brown with dried food on them and observed sitting beside the tilt skillet. Dietary staff were observed working on the tray line assembling lunch trays, and multiple trays for lunch service were cracked, worn, and stained. (continued on next page)

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	395699	A. Building B. Wing	09/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sweden Valley Manor	1028 East Second Street Coudersport, PA 16915

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A white open plastic cart beside the service line (near the food) was observed with a buildup of dried food debris on the ridges of the top of the cart, dried food and dried liquid spills were observed on the base of the cart and shelf ledges for holding the trays. Pieces of the plastic frame and top were broken off leaving uneven sharp edges. An additional plastic orange and gold open cart beside the tray line that staff used to place resident trays on to deliver to the nursing units was observed with cracks throughout the top and a large hole in the center of the plastic top of the cart. Dried food and dried liquid spills were also observed throughout the cart. A lower shelf of the steam table area was observed with dust, dried food, debris, and dried spills. A large round clear plastic container was observed sitting under the drain area of the steam table on the shelf. The container was significantly stained brown and black. Two large roasting pans and a stack of sheet trays under the steam table area were observed with brown/black burnt on buildup surrounding the pans. As lunch meals were being assembled, an unidentified dietary staff member was observed placing a slice of bread directly on a white shelf area attached to the side of the steam table, obtaining a piece of meat from the steam table and placing it on the bread, topping it with another piece of bread, cutting it in half, then placing in on a plate, which was sitting on the same shelf area. The staff member had been observed obtaining plates, bowls, and other equipment and setting them in the same area as food was plated for lunch prior and after the sandwich was assembled directly on the same surface. Several plastic containers were observed holding loose cereal on a shelf across from the meal tray service line. The exterior of the containers was sticky and contained a buildup of dust and debris. Employee 3, nutrition services supervisor, stated the containers were full of cereal and were cleaned and refilled every three to four days. One container was labeled min wheats, with a date of February 29, 2024, written on the label with no expiration date. Another dietary staff member in the area yelled, we don't use that one as much. One of the containers contained multi-colored rings of cereal and had no label or date. A container was labeled Rice Krispies with a date of March 14, 2024, Corn Flakes with a date of March 4, 2024, Frosted Flakes with a date of March 4, 2024, and Bran with a date of March 21, 2024, with no expiration date. A clear plastic sheet protector was observed lying on the shelf under the cereal containers with a list of residents on thickened liquids the sheet protector was covered in dried food/liquid splatter. A black three tier utility cart parked along the wall with a bin of ice cream cups on it by the tray line was soiled with dried spills, food, and dust. Three metal drawers located along the wall under a countertop area were observed with handles broken off two of the drawers. The fronts of the drawers were covered in dust, dried spills, and dried food. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A food slicer was observed on the counter beside the drawers covered in a clear plastic bag. The plastic bag had dried food splatter on it. The blade of the slicer and the area below the blade of the slicer had dried food and debris on it. An additional three tier utility cart in the area with a stack of clean additional resident meal trays was soiled and the trays were stained and cracked. The ceiling lights observed throughout the kitchen had visible exterior dust in multiple areas and dead insects with several containing dead insects inside the light covers. A plastic speed rack with a tray of fruit cups on it was observed beside the tray assembly line. The rack had dried white substances on several of the pan shelf ledges and other dried food debris on the rack. A [NAME] holding racks of bowls beside the line that staff were using for tray assembly was covered in dust and dried food. The tilt skillet contained a dried brown buildup on the top of the lid. The round handle used to operate the skillet was covered in dust and dried food. The flooring area throughout the kitchen under equipment and along all wall edges and corners contained significant black buildup and buildup of dirt and debris. A black tiered cart being used by a dietary staff member to hold clean plates being used for service by the steam table was soiled with dried food and debris buildup in the handle ledge areas. A plastic cabinet mounted to the wall over the microwave area contained black buildup on the front of the cabinet doors extending halfway up the cabinet. The flooring in the dishr oom contained debris and black buildup. The pipes running under the dish machine were covered in dried brown and liquid runs. Two round ceiling vents had visible dust. A control panel door for the dish machine was completely discolored and covered solid in rust colored metal. The exterior of a large garbage can in the dish room was covered in dried liquid runs and dried food. The interior of the bin under the bag contained dried food, stained wrappers, and salt/sugar packets. The light covers in the dish room were dusty and contained dead insects in the interior of the lights The flooring in the three compartment sink area was extremely dirty extending under the sink and along wall edges with a buildup of black debris. Dried liquid splatter was observed all along the wall behind the sink. The door to the dry storage area was observed to have three large metal air vents on the door. The vents were covered in dust. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The open metal wire rack shelving in the dry storage room where multiple food products were stored were covered in thick dust surrounding the edges and frames of the shelving units. Multiple lower shelves in the dry storage area six inches off the floor were open wire racks with food products stored on the shelves. There was no solid barrier to prevent the potential of contamination from mop water splash or sweeping debris from reaching the products. Two of the lower open wire rack shelves that did have a sheet of plastic covering holding jugs of oil, cherries, pickles, mayonnaise, and dressings contained dried spills, significant debris, and dust. The flooring in the dry storage area was worn, and dirt and debris were observed under the shelving areas. A bread rack with multiple packs of bread products on it was observed with significant dirt/dust and dried food debris covering the frame/base of the rack. A plastic delivery cart parked beside the bread area holding a purse was observed with soiled shelves, dried food debris, and multiple hairs stuck with dust to the lower shelf edge. A plastic tray was observed on one of shelves in the dry storage area holding multiple plastic serving bowls and lids containing cereal. There was no date to indicate when the cereal was placed in the bowls or when they needed to be used by. The walk-in freezer had significant ice buildup on the flooring to the left and right of the entrance. The shelves had a buildup of ice upon entering the freezer, boxes of food products in the same area inside the door were observed with ice covering the boxes. The lower open wire rack shelves in the freezer within six inches from the floor with food product stored on them did not contain any barrier to protect the products from the potential contamination of mop water splash or sweeping debris. A plastic container of strawberries was on a shelf and coated with frost buildup on the exterior of the container. The exterior of the walk-in cooler and walk-in freezer doors were visibly dirty surrounding the handle areas and diamond plate covering the lower portions of the doors. The walk-in cooler floor contained dried food, grapes, cardboard pieces, and other debris covering the floor and under the shelves. The white wall area observed through the shelf where food products were stored in the cooler was covered in a black substance. Two of the lower open wire rack shelves within six inches from the floor with food products stored on them did not contain any solid barrier to prevent the potential contamination from mop water splash or sweeping debris. Plastic barriers on the remaining shelves were covered in dried food debris and dried spills. The metal shelving throughout was covered in dust and debris. The shelves under the gallons of milk were covered in a dried white flakey substance. A clear hard plastic flat container was observed on one of the shelves in the cooler labeled as jelly. The lid on the container was significantly cracked throughout the lid. The condenser fan covers in the cooler were covered in dust buildup. The exterior of a trash bin located under the hand washing sink was covered in dried spills and dirt. Two additional large garbage cans across from the hand washing sink were observed with significantly soiled exterior lids and base. A round white trash bin next to them in which Employee 2, corporate dietitian, indicated mop heads were in, was black on the exterior with dust and dirt and the lid was broken entirely in half resting on the top of the can. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A hallway outside the back kitchen entrance was observed with multiple open boxes of paper products such as foam food containers, cups, and bowls with product taken out of the open boxes. The boxes were stored directly on the floor. The above findings were reviewed with the Nursing Home Administrator and Director of Nursing on September 20, 2024, at 11:13 AM. 483.60 (i)(2) Food store, distribute, maintain, sanitary Previously cited 10/20/23, 12/19/23 28 Pa. Code 201.14 (a) Responsibility of licensee