

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395006	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/09/2026
NAME OF PROVIDER OR SUPPLIER St Joseph's Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 1616 Huntingdon Pike Meadowbrook, PA 19046	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(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. Based on observation and staff interview, it was determined that the facility failed to store food in a sanitary manner in the main kitchen, two of seven resident pantries (Green Valley and the Meadows), and one of seven resident dining service areas (Green Valley). Findings include: Observation during the tour of the main kitchen, the [NAME] Valley resident serving area, and the [NAME] Valley resident pantry on January 6, 2026, beginning at 10:15 a.m., revealed the following: In the main kitchen, the floor mixer was in use and had areas of peeled paint on the front and top of the motorhead above the mixing bowl. In the [NAME] Valley resident dining service area refrigerator, there were four cups of yogurt with a use-by date of January 2, 2026. In the [NAME] Valley resident pantry refrigerator there was a carton of milk with a use-by date of January 4, 2026, and one cup of yogurt with a use-by date of January 2, 2026. Observation of the Meadows resident pantry refrigerator on January 7, 2026, at 11:23 a.m., revealed one large carton of apple juice with a use-by date of December 10, 2025. There was a large carton of opened cranberry juice that was not dated. There was a container of five pancakes that was dated use-by January 5, 2026. In an interview on January 6, 2026, at 11:00 a.m., the Executive Chef confirmed that expired food products should have been discarded. CFR 483.60(i) Food Safety Requirement Previously cited 2/13/2528 Pa. Code 201.14(a) Responsibility of licensee. 28 Pa. Code 201.18(b)(3)(e)(2.1) Management.		

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

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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** Based on clinical record review and staff interview, it was determined that the facility failed to complete an accurate Minimum Data Set (MDS) assessment for two of 36 sampled residents. (Residents 4 and 13) Findings include: Clinical record review revealed that Resident 4 had diagnoses that included fibromyalgia (widespread body pain and fatigue) and depression. Review of the MDS assessment dated [DATE], revealed that Sections P (Restraints and Alarms) incorrectly indicated that the resident used a restraint, but less than daily. There was no documentation in the clinical record that indicated Resident 4 used any type of restraint during the review period. Clinical record review revealed that Resident 13 had diagnoses that included peripheral vascular disease and chronic embolism. Review of the MDS assessment dated [DATE], revealed that Section N (Medications) incorrectly indicated that the resident was receiving an anticoagulant medication during the previous seven days. There was no documented evidence that Resident 13 had been administered an anticoagulant medication during the review period. In an interview on January 8, 2026, at 5:14 p.m., the Registered Nurse Assessment Coordinator confirmed that Residents 4 and 13's MDS assessments were inaccurate.		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, observation, and resident and staff interview, it was determined that the facility failed to provide services to maintain adequate grooming and hygiene for three of 36 sampled residents. (Residents 2, 102, and 245) Findings include: Clinical record review revealed that Resident 2 had diagnoses that included muscle weakness, end stage renal disease, and depression. The Minimum Data Set (MDS) assessment dated [DATE], revealed that Resident 2 required maximum assistance with hygiene and self-care and had no cognitive impairment. Review of the care plan revealed that staff were to assist the resident with hygiene and self-care, including nail care on bath day and as necessary. On January 6, 2025, at 12:46 p.m., the resident was observed in his room. His nails were long and dirty. He stated that he preferred short clean nails and that staff had not offered to provide nail care recently. On January 8, 2026, at 11:50 a.m., the resident was observed in his wheelchair. His nails remained long and dirt was observed underneath them. He stated that staff had not offered to provide nail care during his last shower and he would like his nails cut. Clinical record review revealed that Resident 102 had diagnoses that included muscle weakness and depression. The MDS assessment dated [DATE], revealed that Resident 102 required partial assistance with hygiene and self-care and had no cognitive impairment. Review of the care plan revealed that staff were to assist with the resident's hygiene and self care, including nail care on bath day and as necessary. On January 6, 2026, at 2:26 p.m., the resident was observed sitting in his wheelchair. His nails were long and dirty. The resident stated that staff were to cut his nails regularly but had not offered to provide nail care recently despite his repeated requests for help. On January 8, 2026, at 11:45 a.m., the resident was observed sitting in his wheelchair. His nails remained long and dirty. He stated that staff had not offered to provide nail care in several weeks, that he was very frustrated, and that he would like his nails cut and cleaned. Clinical record review revealed that Resident 245 had diagnoses that included muscle weakness, lack of coordination, and hemiplegia (paralysis on one side of the body) and hemiparesis (one sided muscle weakness) affecting the left non-dominant side. The MDS assessment dated [DATE], revealed that Resident 245 was dependent on staff for hygiene and self-care and had no cognitive impairment. Review of the care plan revealed that staff were to assist with the resident's hygiene and self-care, including nail care on bath day and as necessary. On January 6, 2026, at 12:35 p.m., the resident was observed sitting in his chair. His nails were long and jagged. In an interview at this time, the resident stated that staff had not offered to trim his nails and if offered, he would not refuse. On January 8, 2026, at 11:25 a.m., the resident was observed sitting in his chair. His nails remained long and jagged. In an interview on January 9, 2026, at 12:00 p.m., the Director of Nursing confirmed that nail care was to be done on shower days and as needed. 28 Pa. Code 211.12(d)(1)(5) Nursing services.		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. Based on a clinical record review and staff interview, it was determined that the facility failed to implement physicians' orders for three of 37 sampled residents. (Residents 5, 29 and 201)684Based on a clinical record review and staff interview, it was determined that the facility failed to implement physicians' orders for three of 37 sampled residents. (Residents 5, 29 and 201)Findings include: Clinical record review revealed that Resident 5 had diagnoses that included Alzheimer's Disease, hypertensive chronic kidney disease, and type II diabetes. A physician's order dated August 21, 2024, directed staff to administer a blood pressure medication (atenolol) one time a day. The physician ordered that staff not administer the medication if the resident's heart rate was less than 55 beats per minute. Review of Resident 5's Medication Administration Records (MAR) for October, November, and December of 2025, revealed that the staff administered atenolol once each in October and November, and twice in December when Resident's 5's heart rate was less than 55 beats per minute. Clinical record review revealed that Resident 29 had diagnoses that included hypertension (high blood pressure), chronic kidney disease, and heart disease. A physician's order dated August 21, 2025, directed staff to administer a blood pressure medication (amlodipine besylate) one time a day. The physician ordered that staff not administer the medication if the resident's systolic blood pressure (SBP, the first measurement of blood pressure when the heart beats and the pressure is at its highest) was less than 135 millimeters of mercury (mm/Hg). Review of Resident 29's Medication Administration Records (MAR) for September, October, November, and December of 2025, and January of 2026, revealed that the staff administered amlodipine 20 times in September, 15 times in October, 18 times in November, 22 times in December, and four times in January when Resident's 29's SBP was less than 135mm/Hg. Clinical record review revealed that Resident 201 had diagnoses that included Alzheimer's Disease, hypertension, and type II diabetes. A physician's order dated July 18, 2023, directed staff to administer a blood pressure medication (carvedilol) one time a day. The physician ordered that staff not administer the medication if the resident's heart rate was less than 60 beats per minute or if their SBP was less than 110mm/Hg. Review of Resident 201's Medication Administration Records (MAR) for October, November, and December of 2025, revealed that the staff administered carvedilol twice each in October, November, and December when Resident's 201's SBP was less than 110mm/Hg. In an interview on January 9, 2026, at 12:10 p.m., the Director of Nursing confirmed medications were administered outside of parameters ordered by the physician for Residents 5, 29, and 201.42 CFR Part 483.25 Quality of Care. Previously cited 4/25/2528 Pa. Code 211.12(d)(1)(5) Nursing services.		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility documentation review, observation, and staff interview, it was determined the facility failed to implement safety interventions for one of eight sampled residents at risk for falls. (Resident 15) Findings include: Clinical record review revealed that Resident 15 had diagnoses that included abnormality of gait and mobility, muscle weakness, and difficulty in walking. The Minimum Data Set assessment dated [DATE], revealed that Resident 15 required staff assistance for bed mobility and transfers. Review of facility documentation dated September 10, 2025, revealed the resident was found on the floor after rolling out of bed, with a new intervention to place falls mats on both sides of the bed. Review of the care plan identified that the resident was at risk for falls related to gait dysfunction with an intervention that staff were to place fall mats on both sides of the bed to prevent injury. Observations on January 6, 2026, at 11:45 a.m. and 2:00 p.m., and January 7, 2026, at 12:26 p.m., revealed that Resident 15 was in bed and there was no fall mat placed on the window side of the bed. In an interview on January 9, 2026, at 11:56 a.m., the Director of Nursing confirmed that floor mats should have been in place on both sides of the bed. 28 Pa. Code 211.12(d)(1)(5) Nursing services.		