

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: 395023	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/19/2026
NAME OF PROVIDER OR SUPPLIER Phoebe Richland Hcc		STREET ADDRESS, CITY, STATE, ZIP CODE 108 South Main Street Richlandtown, PA 18955	
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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on clinical record review and observation, it was determined that the facility failed to ensure that dignity was maintained for one of 26 sampled residents. (Resident 126) Findings include: Clinical record review revealed that Resident 126 had diagnoses that included parkinsonism, urinary retention, and hypotension. On February 12, 2026, the physician ordered for the resident to have an indwelling catheter for urination. Observations on February 17, 2026, from 12:04 p.m. through 12:35 p.m., and February 18, 2026, from 11:59 a.m. through 12:30 p.m., revealed Resident 126 sitting in a wheelchair in the dining room. The Foley catheter bag was not covered and contained urine. Multiple residents and staff were present in the area during those time periods. In an interview on February 19, 2026, at 10:45 a.m., the Director of Nursing confirmed that Resident 126 should have been provided with a cover for the catheter bag when in the dining room. 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

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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 ensure that the Minimum Data Set (MDS) assessments were completed to accurately reflect the residents' current status for two of 26 sampled residents. (Residents 4, 28) Findings include: Clinical record review revealed that Resident 4 had diagnoses that included atherosclerotic heart disease, heart failure, and cerebral infarction (stroke). The MDS assessment dated [DATE], incorrectly indicated in Section H (Bladder and Bowel) that Resident 4 had an indwelling catheter. There was no documented evidence that Resident 4 had an indwelling catheter during the MDS review period. Clinical record review revealed that Resident 28 had diagnoses that included an artificial opening of the urinary tract and dementia. A physician's note dated January 7, 2026, indicated that Resident 28 had nephrostomy tubes in place. Review of the care plan revealed the resident had bilateral nephrostomy tubes in place. The MDS assessment dated [DATE], indicated in Section H (Bladder and Bowel) that Resident 28 had an indwelling catheter and incorrectly indicated the resident was always incontinent of urine. In an interview on February 19, 2026, at 10:45 a.m., the Director of Nursing confirmed that Resident 4's and 28's MDS assessments were inaccurate and that Resident 28's urinary continence should not have been rated due to the use of nephrostomy tubes.		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, review of facility documentation, and staff interview, it was determined that the facility failed to develop and implement a comprehensive care plan that addressed individual resident needs as identified in the comprehensive assessment for two of 26 sampled residents. (Residents 42, 108) Findings include: Clinical record review revealed that Resident 42 was admitted to the facility on [DATE], and had diagnoses that included displaced right femur fracture, anxiety, and dementia. The Minimum Data Set (MDS) Care Area Assessment (CAA) summary dated January 27, 2026, noted that the resident's psychotropic drug use was to be addressed in the care plan. Review of the medication administration records for January and February 2026, revealed the resident received an antianxiety medication (lorazepam), classified as a psychotropic drug, daily during the review period. Interventions to address Resident 42's psychotropic drug use were not included in the care plan. Clinical record review revealed that Resident 108 was admitted to the facility on [DATE], and had diagnoses that included atrial fibrillation, neuromuscular dysfunction of the bladder, and urinary retention. The MDS assessment and CAA summary dated January 28, 2026, noted that the resident had an indwelling catheter and it was to be addressed in the care plan. Interventions to address Resident 108's indwelling catheter were not included in the care plan. In an interview on February 19, 2026, at 1:30 p.m., the Director of Nursing confirmed that the identified care areas were not addressed in the care plans. 28 Pa. Code 211.12(d)(1)(5) Nursing services.		

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** Based on clinical record review, observation, and staff interview, it was determined that the facility failed to provide treatment and services to prevent further limitations in range of motion for one of six sampled residents who required use of a splint and/or had limitations in range of motion. (Resident 7) Findings include: Clinical record review revealed that Resident 7 had diagnoses that included a stroke with paralysis on the right side. The Minimum Data Set assessment dated [DATE], indicated that the resident had memory impairment, required assistance with dressing, and had impairment in range of motion on both sides of the upper and lower extremities. On April 29, 2025, a physician ordered for staff to apply a resting hand splint to the right hand after morning care. Review of an occupational therapy Discharge summary dated [DATE], revealed that there was a recommendation for staff to apply a resting hand splint to the right hand after morning care for contracture management. The summary indicated that the resident was tolerant of the splint with separator for at least eight hours a day. The therapist indicated that the existing orders in place remained appropriate for staff to apply the splint after morning care and remove the splint after dinner. Observations on February 17, 2026, at 11:40 a.m., 12:10 p.m., 12:44 p.m., and 1:30 p.m., revealed that the resident was dressed and seated in a chair. There was no resting hand splint on her right hand during the observations. In an interview on February 18, 2026, at 11:00 a.m., the Administrator stated that the right resting hand splint should have been in place as ordered by the physician and as recommended by the occupational therapist. 28 Pa. Code 211.12(d)(1)(3)(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 and review of facility documentation, it was determined that the facility failed to provide adequate supervision to prevent falls for a resident with behavioral symptoms for one of six sampled residents who experienced falls. (Resident 33) Findings include: Clinical record review revealed that Resident 33 was admitted to the facility on [DATE], with diagnoses that included dementia with agitation, insomnia, traumatic subdural hemorrhage (bleeding between the brains surface and outer covering), and anxiety disorder. The Minimum Data Set assessment dated [DATE], indicated that the resident had memory impairment, exhibited wandering behavior and had a history of falling. A review of the care plan revealed the resident was at risk for falls and injury due to an unawareness of safety needs, dementia, and impaired mobility. Review of facility documentation dated January 10, 2026, revealed that the resident was found on the floor on his back in his room holding onto the lever of his roommate's recliner at 3:30 a.m. The facility documentation indicated that the resident was trying to get into bed and fell and that he had restlessness. Review of facility documentation dated January 13, 2026, revealed that the resident was found on the floor in his room at 3:00 a.m. The documentation indicated that the resident was trying to get into bed and fell and that he was likely to have terminal restlessness. On January 15, 2026, the social worker noted that the resident had been exhibiting wandering behavior and had cognitive impairment related to his dementia. On January 16, 2026, social services documented that the resident was moved to a locked dementia unit due to behavior concerns. On February 5, 2026, at 11:03 p.m., a nurse documented a behavioral note that indicated the resident had an increase in restlessness and anxious behaviors throughout the shift. He was noted to continually seek a wall rail to pull himself up from his chair and that he became impulsive upon redirection and reassurance. He was noted with agitation and was administered an anti-anxiety medication at 10:00 p.m. He continued with insomnia, restlessness, and an angry mood at that time. A nurse documented that the anti-anxiety medication had been ineffective. Further review of a nursing behavior note dated February 6, 2026, at 5:17 a.m., revealed that the resident had refused to lie down or get ready for bed until about 2:00 a.m. He was noted as paranoid, angry, and verbally demanding. He was noted as increasingly agitated when spoken to and was pacing in his wheelchair. He went to bed at approximately 2:40 a.m. Review of additional facility documentation dated February 6, 2026, revealed that the resident was found in his room standing near his bed at 3:17 a.m., stating that he needed to use the bathroom. At that time, the resident turned quickly and fell onto his right side, striking his head on the dresser. The facility failed to provide adequate supervision to prevent falls for a resident who had agitated and restless behaviors and had three falls around the same time during the night within 30 days of admission to the facility. 28 Pa. Code 211.12(d)(1)(5) Nursing services.		