

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  395031	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/05/2025
NAME OF PROVIDER OR SUPPLIER  Haven Place Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE  24 Cree Drive Lock Haven, PA 17745	

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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<p>F 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Keep residents' personal and medical records private and confidential.</p> <p>Based on review of select facility policies and procedures, observation, and staff interview, it was determined that the facility failed to ensure a resident's privacy during a medication pass on one of two nursing units (First Floor) and for one of 18 sampled residents (Resident 11). Findings include: The facility policy entitled Administering Medications, last reviewed without changes August 7, 2025, revealed medications that are given by routes other than mouth, nursing staff will administer in such a way as to maintain privacy. Oral medications can be given in a common area with the resident's consent. Observation of the First Floor nursing unit on September 2, 2025, at 11:55 AM revealed Employee 19 (licensed practical nurse) was in Resident 11's room administering his enteral feed. Resident 11's shirt was pulled up, and he was exposed to anyone walking in the hallway. Resident 11's roommate was sitting in his personal chair watching Employee 19 administer Resident 11's enteral feed. There was no privacy curtain pulled. Interview with Employee 19 on September 2, 2025, at 11:57 AM confirmed she is to pull Resident 11's curtain to ensure his privacy. These findings were reviewed with the Nursing Home Administrator and Director of Nursing during a meeting on September 3, 2025, at 2:00 PM. 28 Pa. Code 201.14(a) Responsibility of licensee</p>

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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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop and implement policies and procedures to prevent abuse, neglect, and theft.</p> <p>Based on review of select facility policies and procedures, employee personnel records, and staff interview, it was determined that the facility failed to implement an abuse prohibition policy that required a thorough investigation of prospective employee's employment history for five of five newly hired employees reviewed (Employees 1, 2, 3, 4, and 5). Findings include: The facility policy entitled Staff Screening, last reviewed without changes August 7, 2025, revealed the facility will utilize reasonable and prudent criminal background screening and reference checks for prospective staff. Prior to employment or commencement of a contract, the facility will verify and document or obtain a copy of the following information that may include but not limited to previous and/or current employer regarding work history, criminal background checks, national sex offender public website, Office of Inspector General Exclusion Screening, State Exclusion screening, current licenses and certifications, and references. Review of Employee 1's (housekeeper) personnel record revealed a hire date of July 2, 2025. Employee 1's personnel record contained no evidence that the facility attempted to obtain personal and/or professional reference information (whether favorable or unfavorable). In accordance with Act 13 Elder Abuse Mandatory Reporting and Act 169 Criminal Background Checks, nursing facilities are required to obtain a criminal background check on all newly hired employees. Facilities are required to obtain the Pennsylvania State Police (PSP) background check within 30 days of hire on all prospective employees. If the applicant has not been a Pennsylvania resident for the two years before application, they will need to have a PSP criminal history background check completed and a Federal Bureau of Investigation (FBI) Background Check. Review of Employee 4's (registered nurse) personnel record revealed the facility hired her on May 18, 2025, and her criminal background check was not completed until September 2, 2025. Review of Employee 1 (housekeeper), Employee 2 (registered nurse), Employee 3 (nurse aide), Employee 4 (registered nurse), and Employee 5's (recreation aide) personnel records revealed no evidence that the facility determined whether these five employees resided in Pennsylvania for the last two years or completed an FBI background check on them. Interview with Employee 13 (human resources) on September 4, 2025, at 9:45 AM, she confirmed the above findings for Employees 1, 2, 3, 4, and 5. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa Code 201.18(b)(1)(3)(e)(1) Management 28 Pa Code 201.19(8) Personnel policies and procedures</p>		

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<p>F 0676</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason.</p> <p>Based on clinical record review and staff interview, it was determined that the facility failed to complete a restorative nursing ambulation program for one of four residents reviewed for activities of daily living concerns (Resident 8). Findings include: Clinical record review for Resident 8 revealed a restorative nursing ambulation program that indicated she was to be ambulated with extensive assistance of two staff 20-40 feet using a front wheeled walker and a third person was to follow with a wheelchair. The program was to be completed on day shift. Further clinical record review reviewed of Resident 8's restorative ambulation program for August 2025, revealed that the staff documented not applicable (NA) on August 5, 8, 9, 10, 12, 13, 14, 15, 22, 27, 28, 2025, with no explanation documented. Interview with the Nursing Home Administrator and Director of Nursing on September 4, 2025, at 2:30 PM revealed that there was no further staff documentation for Resident 8's restorative ambulation program. The facility failed to complete the restorative nursing ambulation program for Resident 8 ordered. The above information for Resident 8 was reviewed in a meeting with the Nursing Home Administrator and Director of Nursing on September 4, 2025, at 2:30 PM. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>Based on observation, clinical record review, and resident family and staff interview, it was determined that the facility failed to provide a dependent resident with activities of daily living assistance for one of four residents reviewed (Resident 12). Findings include: Observation of Resident 12 on September 2, 2025, at 11:42 AM revealed several days of beard growth on his face. During an interview with Resident 12 at this time, he stated he likes to be clean shaven, but he doesn't know where staff put his razor. Observation of the room revealed that a razor was on his nightstand out of his reach. Further observation of Resident 12 revealed his fingernails were long with brown substances under several nails. Clinical record review revealed the facility admitted Resident 12 on November 11, 2024, with diagnosis including cerebral palsy (brain disorder affecting body movement and muscle coordination). Review of Resident 12's plan of care initiated November 8, 2024, revealed Resident 12 has cerebral palsy, and has declined in his activities of daily living (ADL). Resident 12's care plan was revised on August 3, 2025, noting Resident 12 had the potential for decreased function in level of functional abilities due to limited mobility, weakness, deconditioning, and cerebral palsy. A review of Resident 12's most recent annual MDS (Minimum Data Set, an assessment completed at specific intervals to determine resident care needs) dated August 11, 2025, indicated nursing staff assessed Resident 12 as requiring substantial to maximum assistance for personal hygiene (the ability to maintain personal hygiene, including combing hair, shaving, applying makeup, washing/drying face and hands). There was no documentation indicating staff were providing shaving assistance, or nail care to Resident 12. Interview with the Nursing Home Administrator and Director of Nursing on September 4, 2025, at 2:20 PM confirmed these findings. The Director of Nursing confirmed Resident 12 is unable to shave himself or complete nail care. 483.24(a)(2) ADL Care Provided for Dependent Residents Previously cited deficiency 10/4/24 28 Pa. Code 211.12(d)(1)(5) Nursing services</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>Based on clinical record review, and staff interview, it was determined that the facility failed to provide the highest practical care related to medication administration for one of 18 residents reviewed (Resident 12). Findings include: Clinical record review revealed the facility admitted Resident 12 on November 11, 2024. A physician's order dated June 30, 2025, instructed nursing staff to inject 80 milligrams (mg) of Humira (medication used to treat various autoimmune conditions) subcutaneously (under the skin) one time for psoriasis (chronic skin disorder that causes scaling and inflammation) when it arrives from the pharmacy. Further review of Resident 12's physician orders revealed an order dated July 7, 2025, instructing nursing staff to administer 40 mg of Humira subcutaneously one time for psoriasis, and an order dated July 21, 2025, for nursing staff to inject 40 mg of Humira every 14 days for psoriasis. Further review of Resident 12's clinical record revealed nursing documentation dated June 30, 2025, at 11:52 PM revealed Resident 12's Humira was unavailable, and the facility was awaiting prior authorization from the pharmacy. Nursing documentation dated July 8, 2025, at 1:49 PM revealed the facility was still awaiting prior authorization from the pharmacy for Resident 12's Humira. Nursing documentation dated July 21, 2025, at 8:29 PM revealed Resident 12's Humira was unavailable. Nursing documentation dated August 4, 2025, at 8:13 PM revealed Resident 12's Humira was still unavailable. Nursing documentation dated August 18, 2025, at 1:20 PM noted a new insurance authorization was submitted for Resident 12's Humira. At 8:53 PM nursing staff noted Resident 12's Humira was still not available from the pharmacy, and staff were unable to give Resident 12's Humira. Nursing documentation dated September 1, 2025, at 10:13 PM revealed Resident 12's Humira was not available, due to prior authorization needed. At 11:48 PM nursing staff noted Resident 12 has been ordered Humira since June 30, 2025, and he has never received a dose. Documentation noted multiple notes stating awaiting authorization since that date. Provider notification form submitted. Interview with the Nursing Home Administrator and Director of Nursing on September 5, 2025, at 10:35 AM confirmed these findings. They were unable to provide any documentation that Resident 12's physician was made aware of the unavailability of Resident 12's Humira until September 1, 2025. The facility failed to provide the highest practical care related to Resident 12's medication regime. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services</p>		

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p>Based on clinical record review and staff interview, it was determined that the facility failed to complete a restorative range of motion program as ordered for one of four residents reviewed (Resident 8). Findings include: Clinical record review for Resident 8 revealed that she was on a restorative active range of motion program (ROM, exercises using muscles to move a body part without assistance) to her bilateral upper extremities for 10 repetitions twice a day and her bilateral lower extremities 20 repetitions twice a day. Review of Resident 8's restorative range of motion program documentation for June 2025, revealed the following: Not applicable (NA) was documented on June 18, 24, 26, and 28 on evening shift, and there was no documentation for the program on dayshift for the dates of June 8, 22, and 24, 2025, and on evening shift for the dates of June 1, 2, 3, 7, 8, 9, 10, 12, 13, 14, 15, 16, 21, 22, 29 and 30, 2025. Review of Resident 8's restorative range of motion program for July 2025, revealed the following: NA was documented on July 2, 3, 4, 7, 10, 12, 13, 18, and 26, 2025 on evening shift, and there was no documentation for the program on evening shift for the dates of July 8, 9, 14, 15, 16, 22, 23, 24, and 27, 2025. Review of Resident 8's restorative range of motion program documentation for August 2025, revealed the following: NA was documented on August 5, 8, 9, 10, 12, 13, 14, 15, 27, and 28, 2025, on day shift, and on August 4, 5, 9, 10, 15, 21, and 23, 2025, on the evening shift. There was no documentation on dayshift for August 2, 2025, and no documentation on evening shift for August 2, 3, 7 and 13, 2025. The Nursing Home Administrator and Director of Nursing were made aware of the concerns with Resident 8's restorative range of motion program during a meeting on September 4, 2025, at 2:30 PM 28 Pa. Code 211.12 (d)(1)(2)(3)(5) Nursing services</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>(continued on next page)</p>

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Based on clinical record review, review of facility documentation, and staff interview, it was determined that the facility failed to appropriately implement a fall intervention to prevent potential resident injury for one of three residents reviewed for falls (Resident 10). Findings include: Clinical record review for Resident 10 revealed a diagnosis list that included Alzheimer's Disease (a brain disorder that leads to a gradual decline in memory, thinking, and the ability to complete simple tasks), a need for assistance with personal care, and abnormalities of gait and mobility. A current physician's order for Resident 10 revealed an order dated March 27, 2025, for a bed alarm and check functioning every shift. Further clinical record review for Resident 10 revealed a significant change Minimum Data Set Assessment (MDS, an assessment completed at specific intervals to determine care needs) dated May 2, 2025, that noted facility staff assessed the resident as having a BIMS (Brief Interview for Mental Status) of 99, which indicated cognitive impairment. Resident 10's care plan revealed that the resident is at risk for falls related to incontinence, unaware of safety needs, and vision and hearing problems. A nursing progress note for Resident 10 dated June 30, 2025, at 1:52 AM revealed the nurse aide reported the resident was sitting on the floor in her room. The documentation noted the resident appeared to be attempting to grab something from her nightstand drawer. The assessment revealed no injuries. The resident was assisted back to bed by staff. Facility documentation for Resident 10 titled, Fall Huddle Investigation Worksheet, and dated June 30, 2025, noted the time of fall as 1:10 AM. The documentation noted the resident had an alarm; however, was documented as no for the question of was the alarm sounding. The documentation further noted a question of if the alarm was not ringing what immediate corrective action was taken and the written response documented, Alarm was on with volume turned down. Volume was turned up. Facility documentation titled, Staff Statements for the Investigative Process, noted a written statement, in part, dated June 30, 2025, from Employee 17, nurse aide, that indicated Employee 17 did not hear the alarm going off. The statement further noted, Alarm not sounding when entering room. Education was provided by the facility to check that the alarm is turned on, volume is on high and functioning properly. A nursing progress note for Resident 10 dated July 16, 2025, at 5:27 PM revealed that staff saw the resident on the floor in the room. The documentation noted, Alarm was on the bed but not turned on. The resident was assisted from the floor by staff to a chair. The resident was then brought to the dining room for the evening meal. Facility documentation for Resident 10 titled, Fall Huddle Investigation Worksheet, dated July 16, 2025, and noted a time of fall as 4:37 PM. The documentation further noted a question of if the alarm was not ringing what immediate corrective action was taken and the written response documented, Alarm wasn't turned on, turned it on. Facility documentation titled, Staff Statements for the Investigative Process, noted a written statement, in part, dated July 16, 2025, from Employee 18, nurse aide; however, the staff signature was not very legible. The print name section on the statement was blank. An interview with the Nursing Home Administrator and Director of Nursing on September 5, 2025, at 1:15 PM indicated the signature was that of Employee 18. The statement noted .But no alarm sound. Further review of the clinical documentation for Resident 10 revealed task documentation (located in the electronic health record where staff document specific care related events for a resident) for June through August 2025. The documentation revealed that staff were to check a bed alarm was in place and check the function every shift. The following dates revealed nothing was documented by staff to ensure the bed alarm was in place and functioning: June 2, 2025, evening shift; June 5, 2025, night shift; June 8, 2025, night shift; June 15, 2025, evening shift; June 28, 2025, night shift; June 29, 2025, day and evening shift; June 30, 2025, night shift; July 5, 2025, evening shift; July 11, 2025, day shift; July 12, 2025, day shift; July 18, 2025, evening shift; July 19, 2025, evening and night shift; July 30, 2025, evening shift; July 31, 2025, night shift; August 27, 2025, night shift; August 31, 2025, night shift. The above findings were reviewed in a meeting with the Nursing Home Administrator and Director of Nursing on September 5, 2025, at 1:15 PM. A follow-up interview with the Nursing Home Administrator on September 5, 2025, at 2:00 PM revealed that the alarm is kept at the end of the bed and it would be difficult for the resident to access and change the alarm settings. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services</p>		

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<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail.</p> <p>Based on observation, clinical record review, review of select facility documentation, and staff interview, it was determined that the facility failed to conduct ongoing assessments to assure that bedrails were used to meet a resident's needs and an ongoing evaluation of risks associated with bedrail usage for one of six residents reviewed for accident hazards (Resident 15). Findings include: Observation of Resident 15's bed on September 4, 2025, at 2:19 PM revealed the bed had bilateral enabler bars. Observation of Resident 15 on September 5, 2025, at 9:15 AM revealed the resident was in bed resting. The bed had bilateral enabler bars. Clinical record review for Resident 15 revealed a diagnosis list that included dementia (a loss of cognitive function that is caused by the permanent damage or death of the brain's nerve cells, or neurons). Further clinical record review for Resident 15 revealed an annual Minimum Data Set Assessment (MDS, an assessment completed at specific intervals to determine care needs) dated July 28, 2025, that noted facility staff assessed the resident's cognitive status as the resident being rarely or never understood. A current physician's order for Resident 15 dated January 16, 2024, revealed an order for bilateral enabler bars to aid with bed mobility and transfers. Facility documentation for Resident 15 revealed a document titled Informed Consent for Use of Bed Rails / Enabler Bars, and was signed and dated by the resident's responsible party on January 6, 2024. Further review of this document revealed the document noted, It is the policy of this facility to provide a safe bed environment for all residents. Only after evaluation and care planning is it deemed appropriate to provide the use of bed rails for an individual resident. In all instances, the least restrictive device, which is effective, will be used. The facility will monitor the resident's status, frequency of use, and adjust care as necessary. The facility has a systemic and gradual process to reduce the use of bed rails / enabler bars and to always ensure the resident's safety. Facility documentation for Resident 15 titled, Enabler Bar Request Form, noted a date of request as January 16, 2024. Review of the clinical documentation for Resident 15's enabler bars revealed no further evidence that the facility conducted any type of ongoing monitoring or re-assessment to assure that the bedrails were used to meet the resident's needs or an ongoing evaluation of risks associated with bedrail use since January 16, 2024. An interview with the Nursing Home Administrator on September 5, 2025, at 1:15 PM confirmed the facility had no further documentation to support any ongoing assessments of Resident 15's enabler bars. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services</p>		

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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.</p> <p>Based on review of facility documentation and staff interview, it was determined that the facility failed to ensure that nursing staff possessed the appropriate competencies and skill sets related to the care and assessment of residents with enteral tube feeding, who utilize a lift, catheter care, medication administration, and dressing changes for five of five employees reviewed for competencies (Employees 6, 7, 8, 9, and 10). Findings include: A review of the facility documentation revealed that the facility had a total of 72 residents receiving medications, 17 residents that utilize lifts, two residents with indwelling urinary catheters (insertion of a tube into the bladder to remove urine), 7 residents with dressing changes, and one resident with enteral tube feedings (device that allows liquid food to enter your stomach or intestine through a tube). A request for nursing staff competencies for enteral tube feeding, lifts, catheter care, medication administration, and dressing changes revealed the facility was unable to provide any competencies for Employees 6 and 7 (registered nurses), and Employees 8, 9, and 10 (licensed practical nurses). The findings were reviewed with the Nursing Home Administrator and Director of Nursing on September 4, 2025, at 2:19 PM. They confirmed the facility could provide no documentation that ensured Employees 6, 7, 8, 9, and 10 had specific competencies and skill sets to care for the residents' needs listed above. 28 Pa. Code 201.20 (a) Staff Development</p>		

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<p>F 0730</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observe each nurse aide's job performance and give regular training.</p> <p>Based on employee personnel record review and staff interview, it was determined that the facility failed to complete a performance evaluation of each nurse aide at least once every 12 months for two of two nurse aides reviewed (Employees 11 and 12). Findings include: The facility noted the following hire dates for two employees reviewed for performance evaluations (EPR, employee performance review): Employee 11's hire date of July 22, 2019. Employee 12's hire date of March 28, 2022. A request to review the annual performance evaluations revealed no documented evidence that the facility completed performance evaluations for Employees 11 and 12 (nurse aides) at least once every 12 months. Interview with the Nursing Home Administrator on September 4, 2025, at 2:19 PM confirmed that performance evaluations were not completed annually on the two employees requested. 28 Pa. Code 201.19 (2) Personnel policies and procedures</p>		

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<p>F 0744</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia.</p> <p>Based on clinical record review and staff interview, it was determined that the facility failed to develop and implement individualized person-centered care plans to address dementia and cognitive loss displayed by one of five residents reviewed (Resident 2). Findings include: Clinical record review for Resident 2 revealed the facility admitted her on April 8, 2025, with diagnoses including dementia (loss of memory, language, problem-solving, and other thinking abilities that interfere with daily life) added August 5, 2025. A review of Resident 2's admission Minimum Data Set Assessment (MDS, a form completed at specific intervals to determine care needs) dated April 9, 2025, indicated that the facility assessed Resident 2 as having a diagnosis of dementia, or cognitive loss. The facility determined that a care plan for dementia and cognitive loss would be developed. A review of Resident 2's care plan revealed that there was no indication that the facility had developed and implemented a person-centered care plan to address the resident's dementia and cognitive loss. The findings were reviewed with the Nursing Home Administrator and Director of Nursing during a meeting on September 5, 2025, at 10:28 AM. They confirmed the facility had no further documentation that the facility developed and implemented an individualized person-centered care plan to address Resident 2's dementia prior to surveyor's questioning. 28 Pa Code 211.12 (d)(1)(3)(5) Nursing services</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  395031	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/05/2025
NAME OF PROVIDER OR SUPPLIER  Haven Place Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE  24 Cree Drive Lock Haven, PA 17745	
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)		
<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>Based on clinical record review, review of select facility policies and procedures, observation, and resident and staff interview, it was determined that the facility failed to properly store resident medications and treatments on one of two nursing units (First Floor Nursing Unit; Resident 12). Findings include: The policy entitled Storage of Medications, last reviewed without changes on August 7, 2025, revealed all medications in the facility will be stored in the pharmacy, or medication rooms according to manufacturer's recommendations and sufficient to ensure proper sanitation, temperature, light, ventilation, moisture control, segregation, and security. All drugs and biologicals will be stored in locked compartments, under proper temperature controls. Observation of Resident 12's room on September 2, 2025, at 11:40 AM revealed a tube of Triamcinolone Acetonide External Cream 0.1 percent (cream used to treat eczema, psoriasis, and dermatitis), Vitamin A&amp;D ointment, and Dermacerin (cream used for minor skin irritations) laying on top of his nightstand. Interview with Resident 12 at this time revealed that the staff apply these creams to his skin, and he did not place the treatments there. The above findings for Residents 12 were reviewed with the Nursing Home Administrator and Director of Nursing during a meeting on September 3, 2025, at 2: 15 PM. The Director of Nursing confirmed the above-mentioned items should not be stored on Resident 12's nightstand. Observation of two of four medication carts on the First Floor Nursing Unit on September 4, 2025, at 10:29 AM revealed two medication carts being utilized by Employee 16, licensed practical nurse. Observation of the medication carts revealed the following: One cart had several unsecured and unidentified medication tablets in the bottom drawer that that included a yellow oval pill, half a blue tablet, half a yellow tablet, and two white colored and round pills. The second cart contained a blue colored, round pill, that was unsecured and unidentified in the bottom of a drawer. There was also a partially used tube of Diclofenac one percent (a medication used to relieve pain and inflammation) observed in a drawer that was not labeled with a resident identifier. The above findings were reviewed in a meeting with the Nursing Home Administrator and Director of Nursing on September 4, 2025, at 2:05 PM. 28 Pa. Code 211.9 (a)(1)(k) Pharmacy services 28 Pa. Code 211.12 (d)(1)(3)(5) Nursing services</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>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 in the facility's main kitchen. Findings include: Findings include: Observation of the facility's main kitchen with Employee 15, Dietary Manager, on September 2, 2025, at 9:45 AM revealed the following: A walk-in cooler contained multiple individually prepared food items (that included bowls of fruit, coleslaw, pudding, pureed and regular peaches, and pasta salad) that were placed on trays and stored on baking racks. The items were open to the ambient air and were not protected from any type of environmental contamination. A plastic chemical dispenser on top of the dishwasher was leaking a blue colored liquid that was pooling on top of the dishwasher and on the floor beneath. A walk-in freezer contained a box labeled gluten bread that was past the noted due date of July 31, 2025, and a bag of frozen corn with no date or labels. A plastic container that held saltine crackers was noted to be broken and had jagged plastic edges. A large vent cover at the corner of the main kitchen had an extensive build-up of a greasy dust on the entire surface. An area between a stainless-steel countertop that contained a tray belt that was no longer in service, per Employee 15, and another stainless-steel countertop contained an extensive build-up of dust and debris that included condiment packets, a single-use butter container, and other debris accumulating on the floor. The findings were reviewed in a meeting with the Nursing Home Administrator and Director of Nursing on September 3, 2025, at 2:31 PM. 28 Pa. Code 201.14 (a) Responsibility of Licensee</p>

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<p>F 0847</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse.</p> <p>Based on review of the facility's arbitration agreement and resident and staff interview, it was determined that the facility failed to ensure that the resident or their representative understood the agreement for one of one resident reviewed (Resident 9) and failed to ensure the facility's arbitration agreement contained information indicating residents or their representatives are able to communicate with federal, state, or local officials. Findings include: Review of the facility's Arbitration Agreement (an agreement that the resident and the facility will resolve legal disputes through binding arbitration, waiving their right to a trial) provided to all residents on admission revealed no evidence that the facility made the residents or their representatives aware that signing the Arbitration Agreement does not exclude them from being able to communicate with federal, state, or local officials, such as federal and state surveyors, other federal or state health department employees, and representative of the Office of the State Long Term Care Ombudsman. Interview with the Nursing Home Administrator on September 5, 2025, at 9:36 AM confirmed these findings. The state operations manual appendix PP, Revision 232x, issued July 23, 2025, S483.70(m)(2)(ii) specifies that the resident or his or her representative acknowledges that he or she understands the agreement. After the arbitration agreement is explained in a manner and form the resident or their representative understands, the facility must ensure there is evidence that the resident or their representative has acknowledged understanding of the agreement. In some cases, the binding arbitration agreement may specify that the resident or his or her representative acknowledges understanding by signing the document. When a signature is used to acknowledge understanding, additional evidence may be needed to establish that in fact the resident or their representative understood what he or she was signing. It may not be sufficient that the resident or their representative signed the document. It is also important that facilities clarify when a signature is used to acknowledge understanding, when it indicates consent to enter into an agreement, or is used for both purposes. Clinical record review for Resident 9 revealed that she signed and entered into an arbitration agreement with the facility on April 17, 2024. Further clinical record review revealed that Resident 9 has a court appointed guardian of her person and property as of April 17, 2014. The guardianship indicated that Resident 9 lacks sufficient understanding or capacity to make or communicate responsible decisions concerning her person and property. Interview with the Nursing Home Administrator and Director of Nursing on September 4, 2025, at 2:16 PM confirmed the above noted findings that Resident 9 has a guardianship and that they do not know of any court proceedings that have occurred to relinquish the guardianship. Interview with Resident 9 on September 5, 2025, at 11:30 AM revealed that she did not know what an arbitration agreement was and did not know that she signed one. The facility failed to ensure that Resident 9 knew and understood what she was signing when she signed and entered into an arbitration agreement with the facility on April 17, 2024. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18(b)(2) Management 28 Pa. Code 201.29(a)(j) Resident rights</p>		

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<p>F 0868</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Have the Quality Assessment and Assurance group have the required members and meet at least quarterly</p> <p>Based on a review of Quality Assessment and Performance Improvement (QAPI) meeting attendance and staff interview, it was determined that the facility failed to ensure the committee consisted of the minimum required members (medical director) at least quarterly. Findings include: Review of QAPI meeting attendance records from October 30, 2024, to the most recent QAPI committee meeting on July 24, 2025, revealed the facility medical director only attended one meeting on July 30, 2025. Interview with the Nursing Home Administrator on September 4, 2025, at 2:05 PM confirmed that the facility failed to ensure at least quarterly QAPI meeting attendance by the facility's medical director (or designee). 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18(b)(3)(e)(3) Management</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>Based on review of select policies and staff interview, it was determined that the facility failed to implement an effective Water Management Program for the prevention and control of water-borne contaminants, such as Legionella (a bacteria that may cause Legionnaires' Disease, a serious type of pneumonia), and failed to implement enhanced barrier precautions or one of six residents reviewed for infection control concerns (Resident 11). Findings include: The CDCs (Centers for Disease Control and Prevention) current Water Management Program Toolkit, Practical Guide to Implementing Industry Standards, indicated that many buildings need a water management program to reduce the risk for Legionella (bacteria that can grow and spread in water systems and can cause a serious type of pneumonia (lung infection) known as Legionnaires' disease) growing and spreading within their water system and devices. Developing and maintaining a water management program is a multi-step process that requires continuous review. Steps to building an effective Legionella water management program include: A description of the building's water system using flow diagrams and a written description to include details like connections to the municipal water supply, how water is distributed, and location of water heaters/boilers. Identification of potentially hazardous conditions such as areas where water temperature could promote Legionella growth or where water flow might be low. Control measures (such as heating, adding disinfectant, or cleaning) that include where and how to monitor them. Control limits are the maximum value, minimum value, or range of values that are acceptable for the control measure. Determine what corrective actions or contingency responses to take when control measures are outside the control limits established. Review of documents provided by Employee 14 (Director of Maintenance) on August 5, 2025, at 10:00 AM related to the facility's water management program revealed that the information provided was a water management plan for another facility. Concurrent interview with Employee 14 revealed that they were unable to locate the current water management plan since the change of ownership and that they plan to adapt the one provided to the surveyor, to fit their facility. An interview with the Nursing Home Administrator on August 5, 2025, at 11:30 AM confirmed the above noted findings related to the facility's water management plan. The facility failed to develop and maintain a water management program to reduce the risk for Legionella growing and spreading within their water system and devices. The facility policy entitled Infection Control Guidelines for all Nursing Procedures, last reviewed without changes on August 7, 2025, revealed it is the policy of the facility to adhere to infection control guidelines to limit or prevent the spread of infection between residents and staff. Enhanced Barrier Precautions will be used to minimize the risk of transmitting infection when providing care to residents that require significant physical contact and are at high risk of acquiring or spreading Multidrug Resistance Organisms (MDRO). Wear personal protective equipment as necessary to prevent exposure to spills or splashes of blood or body fluids, or other potentially infectious materials. Observation of First Floor nursing unit on September 2, 2025, at 11:55 AM revealed Employee 19 (licensed practical nurse) was in Resident 11's room administering his enteral feed. Employee 19 had gloves on, but no gown. There was a sign posted on Resident 11's wall outside his room indicating enhanced barrier precautions, and there was personal protective equipment including gowns and gloves hanging on the door. Interview with Employee 19 at this time confirmed Resident 11 was on Enhanced Barrier Precautions and that she should have been wearing a gown when administering Resident 11's enteral feed. Review of Resident 11's clinical record revealed a physician's order dated March 6, 2023, for enhanced barrier precautions due to his Peg tube (feeding tube inserted into the stomach). These findings were reviewed with the Nursing Home Administrator and Director of Nursing during a meeting on September 3, 2025, at 2:00 PM. 483.80(a)(1)(2)(4)(e)(f) Infection Prevention &amp; Control Previously cited deficiency 12/5/2428 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18(b)(1) Management 28 Pa. Code 211.10(d) Resident care policies 28 Pa. Code 211.12(d)(1) Nursing services</p>		