

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: 395047	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/20/2025
NAME OF PROVIDER OR SUPPLIER Heritage Pointe Rehabilitation and Healthcare Ctr		STREET ADDRESS, CITY, STATE, ZIP CODE 400 South Main Street Doylestown, PA 18901	
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 policy review, observation, and staff interview, it was determined that the facility failed to properly serve food and maintain sanitary conditions in the main kitchen. Findings include: Review of the facility policy entitled, Food: Preparation, last reviewed November 7, 2025, revealed that all staff were to practice proper hand hygiene and glove use. Dining Services staff were responsible for food preparation procedures and using serving utensils appropriately to prevent cross contamination. Observation of the tray line service on November 18, 2025, at 12:35 p.m., revealed the following: Dietary Employee 1 (DE 1) was observed obtaining pork chops and a quiche using only his gloved hands without serving utensils and placing them on resident's meal trays. DE 1 was then observed leaving the tray line, opening the refrigerator door to obtain an item, and pulling up his pants twice. DE 1 returned to the tray line without changing his gloves and continued to pick up the food with his hands while wearing the same gloves. DE 1 was then observed leaving the tray line a second time and opening the door to the dry storage room. DE 1 then obtained bread and cheese and proceeded to make and place a grilled cheese sandwich on a resident tray without changing his gloves. In an interview during this observation period, the Regional Dietary Director confirmed staff should always use serving utensils when handling food and they should change gloves whenever they change tasks. CFR 483.60(i) Food Safety Requirement Previously cited 12/5/2428 Pa. Code 201.14(a) Responsibility of licensee. 28 Pa. Code 201.18(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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observation, clinical record review, and staff interview, it was determined that the facility failed to maintain a medication error rate of less than five percent (%) for one of two nursing units observed during medication administration. (North unit)Findings include: Observation of medication administration on November 19, 2025, from 8:10 a.m. to 8:50 a.m., revealed 32 medication opportunities with two medication errors that resulted in a medication administration error rate of 6.25%. Clinical record review revealed that Resident 52 had diagnoses that included atrial fibrillation (fast heart rate), chronic kidney disease, and hypothyroidism. A review of the physician's order dated February 5, 2025, revealed that staff was to administer one 600 milligram (mg) tablet of a calcium supplement (calcium carbonate) two times a day. Observation of the medication pass on November 19, 2025, at 8:20 a.m., revealed that Licensed Practical Nurse (LPN) 1 administered one tablet of calcium carbonate 500 mg which was 100 mg less than the physician's order. Clinical record review revealed that Resident 63 had diagnoses that included dementia and cerebral infarction. A review of the physician's order dated September 16, 2025, revealed that staff were to administer memantine, a medication to treat the symptoms of dementia, twice a day. Observation of the medication pass on November 19, 2025, at 8:30 a.m., revealed that LPN 1 did not administer the medication. In an interview on November 19, 2025, at 12:15 p.m., the Director of Nursing confirmed that LPN 1 administered the incorrect dose of calcium carbonate. In an interview on November 20, 2025, at 1:12 p.m., the Director of Nursing confirmed that LPN 1 did not administer the memantine on the morning of November 19, 2025. 28 Pa. Code 211.12(d)(1)(5) Nursing services.		

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on facility documentation, resident interview, results of a test tray audit, and staff interview, it was determined that the facility failed to provide food that was palatable and at an appetizing temperature on one of two nursing units. (North wing) Findings include: Review of the facility policy entitled, Food: Quality and Palatability, last reviewed November 7, 2025, revealed that food would be palatable, attractive, and served at a safe and appetizing temperature. Review of Dining Council Minutes from August 14, 2025, and September 25, 2025, revealed that residents had stated that their food was served cold and was not palatable. In a group interview on November 19, 2025, at 11:00 a.m., Residents 7, 14, and 117 reported that it was an ongoing problem that hot food was frequently served cold and food was not palatable. Results of a test tray audit conducted on November 19, 2025, at 12:45 p.m., after the last resident meal tray was served from the dining cart, revealed the grilled chicken was served at a temperature of 125.6 degrees Fahrenheit (F), the brussels sprouts were served at a temperature of 107.5 degrees F, and the roasted potatoes at a temperature of 120.7 degrees F. All food items were cool to taste and not palatable. In an interview during this observation period, the Regional Dietary Director stated that the hot food should have achieved a temperature of 135 degrees Fahrenheit or higher at the time of service. On November 19, 2025, from 12:45 p.m. through 1:05 p.m., Residents 9, 10, and 95 were observed eating lunch in their rooms. They stated that the hot foods were served cool to taste and that they would prefer the food to be hot. 28 Pa. Code 201.14(a) Responsibility of licensee.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on facility policy review, observation, and staff interview, it was determined that the facility failed to follow policies and procedures to prevent the spread of infection on one of two nursing units observed. (North wing) Findings include: Review of the facility policy entitled, Medication Administration, last reviewed November 7, 2025, revealed that staff was to practice hand hygiene prior to administering medication and was to remove medication from source, taking care not to touch medication with bare hands. On November 19, 2025, at 8:50 a.m., licensed practical nurse (LPN) 2 was observed preparing medication for Resident 55. LPN 2 used bare hands to remove seven different medications from the resident's medication card and placed them into a medication cup. LPN 2 then touched the computer mouse, opened the medication cart drawers, selected medication bottles, and poured one pill from the bottle into his bare hand and placed it in the medicine cup. LPN 2 did not perform hand hygiene during these tasks and administered the medications to Resident 55. In an interview on November 19, 2025, at 2:15 p.m., the Director of Nursing confirmed that LPN 2 should not have touched the medications with bare hands. 28 Pa. Code 211.10(d) Resident care policies. 28 Pa. Code 211.12(d)(1)(5) Nursing services.		