

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  395078	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/09/2026
NAME OF PROVIDER OR SUPPLIER  Pine View Healthcare and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE  50 North Malin Road Broomall, PA 19008	

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 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on review of the facility's policy, clinical records review, and staff interview, it was determined that the facility failed to accurately and comprehensively assess and timely provide a wound treatment for two of three residents, reviewed (Resident 1 and 2). Findings: A review of the facility's policy titled Pressure Ulcers/Skin Breakdown-Clinical Protocol, revised in April 2018, revealed that the nursing staff will assess and document an individual's significant risk factor for developing pressure ulcers. The nurse shall describe and document /report a full assessment of the pressure ulcer, including location, stage, length, width, and depth. A review of Resident 1's readmission skin assessment dated [DATE], revealed an identified skin impairment to the right buttock. The assessment failed to reveal a description of the area/wound and size. A review of the physician's progress notes dated February 10, 2026, at 2:56 p.m., reveals Pt (patient) has new small wound on buttock. Wound care follow-up. Wound assessment to the right buttock, identified on February 9, 2026, was not comprehensively assessed until seen by the wound doctor on February 18, 2026. The wound doctor identified the wound as MASD (Moisture Associated Skin Damage), measuring 2.0 x 1.4 x 0.1 cm, with partial thickness. A wound treatment of Medihoney (A dressing that aids and supports debridement and a moist wound healing environment in acute and chronic wounds and burns). An interview with the Director of Nursing (DON) was conducted on March 9, 2026, at 1:00 p.m. The DON confirmed that Resident 1's right buttock wound, identified upon readmission on [DATE], was not comprehensively assessed until seen by the wound doctor on February 19, 2026. A review of Resident 2's readmission skin assessment dated [DATE], revealed scattered scabs on the resident's abdomen and left leg. A review of Resident 2's skin assessment notes dated November 10, 2025, completed by the wound nurse, licensed Employee E3, revealed a Stage 2 Pressure Ulcer (Partial-thickness skin loss with exposed dermis) to the Sacrum (The triangular bone just below the lumbar vertebrae). An interview with Employee E3, conducted on March 9, 2025, at 12:30 p.m., revealed that they recheck the resident's skin within 24 hours upon admission to ensure all skin impairments are identified and addressed. Employee E3 confirmed Resident 2 was admitted with a stage 2 to the sacrum on November 12, 2025. A review of Resident 2's physician's order dated November 13, 2026, revealed an order for Thera Honey (Medihoney) to be applied to the sacrum topically every day shift for the wound. A review of Resident 2's November 2025 Treatment Administration Record (TAR) failed to reveal that Resident 2's sacral wound was treated until November 15, 2026. A review of the wound NP's (nurse practitioner) notes dated November 17, 2025, at 8:40 p.m., revealed: The resident is being evaluated today for a comprehensive skin assessment. The same note revealed, The patient was noted to have intact skin upon assessment today. A review of the wound NP's notes dated November 19, 2025, at 5:30 p.m., documented by the same NP from November 17, 2025, revealed: Patient was seen and evaluated today for PU (pressure ulcer) stage 3 (full-thickness skin loss) to sacrum present on admission from hospital. The wound had a measurement of 3.0 x 2.0 x 0.2 cm. An order to continue Medihoney was ordered and followed. An interview was conducted with the DON on March 9, 2026, at 1:00 p.m. The DON confirmed that there was no documented evidence that Resident 2's sacral wound was provided with treatment from readmission [DATE]), until November 14, 2025. In addition, the (continued on next page)</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 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>DON was not aware of the wound NP's November 17, 2025, inaccurate wound assessment/documentation; they reported that the facility has a new wound NP due to multiple concerns/issues with the previous wound NP. The facility failed to ensure Resident 1 and 2 wounds were accurately and comprehensively assessed, and treatments were timely followed.28 Pa. Code 211.5(f) Clinical records 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services</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 observations, clinical records review, and staff interviews, it was determined that the facility failed to ensure infection control and prevention were implemented during a wound care treatment for two of the two residents reviewed (Resident 1 and 2). Findings: A review of Resident 1's physician's order dated March 8, 2026, revealed an order to cleanse the right buttocks with normal saline solution (NSS), pat dry, apply Medihoney (A dressing that aids and supports debridement and a moist wound healing environment in acute and chronic wounds and burns), and secure with silicone border twice daily for the wound. An observation of Resident 1's right buttock wound care treatment was conducted on March 9, 2026, at 10:40 a.m., with licensed nurse Employee 3. The observation revealed Employee E3 placed tissue paper on the bed beside the resident and laid the wet gauze, Medihoney in a cup and bordered dressing on top of it. Employee E3 proceeded to clean the right buttock wound with a wet gauze, then discarded it in a trash can. Employee E3 continued to apply Medihoney into the wound and applied the newly opened border without changing their gloves and performing hand hygiene. A review of Resident 2's physician's order dated November 13, 2026, revealed an order to cleanse the sacrum (The triangular bone just below the lumbar vertebrae), NSS apply Medihoney daily. An observation of Resident 2's sacrum wound care treatment was conducted on March 9, 2026, at 10:50 a.m., with Employee E3. The observation revealed Employee E3 opened the resident's incontinence brief and assisted in repositioning the resident to their side. Employee E3 laid the cup with a wet gauze inside, the Medihoney (in a medicine cup), and bordered gauze on top of the resident's used incontinence brief in the bed. Employee E3 removed the resident's old sacrum dressing and placed it beside the clean prepared supplies on top of the resident's soiled incontinence brief. Without changing gloves and washing hands, Employee E3 proceeded to clean the sacrum wound with a wet gauze from the cup, then discarded it back in the same cup. Employee E3 continued applying Medihoney to the wound, then covered it with bordered gauze. Employee E3 did not change gloves and did not perform hand hygiene during the entire procedure. An interview was conducted with Employee E3 on March 9, 2026, at 12:00 noon. Employee E3 confirmed that wound supplies were placed on the residents' beds because there were no available side tables. Employee E3 also confirmed they were not changing gloves and performing hand hygiene during wound care treatment because they forgot but knew it should have been done. The above information was conveyed to the Nursing Home Administrator and Director of Nursing on March 9, 2026, at 12:30 p.m. The facility failed to ensure infection control and management were implemented during wound care treatment for Resident 1's right buttock wound and Resident 2's sacral wound. 28 Pa. Code 201.18(b)(1) Management 28 Pa. Code 211.5(f) Clinical records 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services</p>		