

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395104	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/12/2025
NAME OF PROVIDER OR SUPPLIER Saint Mary's Villa Nursing Hom		STREET ADDRESS, CITY, STATE, ZIP CODE 516 St. Mary's Villa Road Moscow, PA 18444	

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 0553</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Allow resident to participate in the development and implementation of his or her person-centered plan of care.</p> <p>Based on clinical record review, facility policy review, observations, and staff and resident interviews, it was determined the facility failed to honor and incorporate the resident's expressed preferences and choices into the care planning process for one of 18 sampled residents (Resident 5). Findings include: A review of Resident 5's clinical record revealed Resident 5 was admitted to the facility August 13, 2013, with diagnoses to include lobar pneumonia (infection that inflames the air sacs in one or both lungs). A review of a Resident 5's quarterly Minimum Data Set Assessment (MDS-a federally mandated standardized assessment conducted at specific intervals to plan resident care), dated August 8, 2025, revealed Resident 5 was cognitively intact with a BIMS score of 13 (brief interview for mental status, a tool to assess the residents attention, orientation and ability to register and recall new information, a score of 13-15 indicates intact cognition). A review of the comprehensive care planning policy last reviewed by the facility on February 27, 2025, revealed the facility will develop a comprehensive person-centered care plan for each resident. The policy further described the plan will be focused on resident choices and abilities with the intent of maintaining or improving resident functional abilities and quality of life. A clinical record review revealed multiple instances of electronic health record documentation of Resident 5's choice to not participate in aspects of care including: BiPap machine (type of noninvasive ventilation that helps you breathe), occupational therapy (treatment that helps people overcome physical, emotional and social challenges), nebulizer treatments (device that turns liquid medicine into a mist), blood pressure readings, meals, weights, skin treatments, and bathing. A review of Resident 5's care plan in effect at the time of the survey did not address the resident's specific choices as described above nor did the care plan accurately reflect resident specific interventions tailored to meet the Resident 5's specific needs related to electing to refrain from participation in various aspects of care. An interview with the Nursing Home Administrator and Director of Nursing on September 12, 2025, at 11:10 AM confirmed the Resident 5's expressed choice was not accurately reflected in the care plan at the time of the survey. 28 Pa. Code 201.29 (a) Resident rights. 28 Pa. Code 211.10 (c)(d) Resident care policies. 28 Pa. Code 211.12(d)(3) Nursing services.</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 - Few</p>	<p>Develop and implement policies and procedures to prevent abuse, neglect, and theft.</p> <p>Based on a review of the facility's abuse prohibition policy, employee personnel files and staff interviews, it was determined the facility failed to fully develop and implement procedures to fully screen four employees out of five to ensure they were eligible for employment in a long term care nursing care facility. (Employees 1, 2, 3, and 4). Findings include: A review of the facility's Resident Abuse policy last reviewed by the facility February 27, 2025, revealed the requirement for screening potential employees included obtaining references from the most recent or previous employer. Review of employee personnel files revealed the following: Employee 1 (Porter): Hired on May 19, 2025. The application listed previous employers, but there was no documentation showing the facility had contacted the most recent former employer to fully screen the individual to ensure the individual was eligible for employment in a long term care nursing facility. Employee 2 (Licensed Practical Nurse): Hired on July 7, 2025. The application listed previous employers, but there was no documentation showing the facility had contacted the most recent former employer. Employee 3 (Licensed Practical Nurse): Hired on July 21, 2025. The application listed previous employers, but there was no documentation showing the facility had contacted the most recent former employer. Employee 4 (Nurse Aide): Hired on July 28, 2025. The application listed previous employers, but there was no documentation showing the facility had contacted the most recent former employer. Interview with the Nursing Home Administrator (NHA) on September 11, 2025, at 10:15 a.m. the NHA verified there was no evidence the facility attempted to obtain information from previous employers and/or current employers for information regarding the employees past work history. The facility failed to follow its own abuse prohibition policy by not verifying previous/current employment for four out of five new hires. 28 Pa. Code 201.18 (e)(1) Management. 28 Pa. Code 201.29 (a)(c) Resident Rights. 28 Pa. Code 201.14(a) Responsibility of Licensee.</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the Resident Assessment Instrument (RAI) Manual, a review of clinical records, resident observation, and staff interviews, it was determined that the facility failed to complete an accurate Minimum Data Set (MDS) for two of 18 residents sampled (Resident 4 & Resident 8). Findings include: The Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual, which provides instructions and guidelines for completing the Minimum Data Set (MDS a federally mandated standardized assessment conducted at specific intervals to plan resident care) dated October 2024, requires the assessment accurately reflects the resident's status, a registered nurse conducts or coordinates each assessment with the appropriate participation of health professionals, and the assessment process includes direct observation, as well as communication with the resident and direct care staff on all shifts. A review of the clinical record revealed Resident 4 was admitted to the facility on [DATE], with diagnoses to include Pneumonia, an unspecified organism (infection that inflames the air sacs in one or both lungs) and Acute Kidney Failure (kidneys suddenly can't filter waste products from the blood). The quarterly MDS dated [DATE], section J (section related to health conditions including fall history) documented Resident 4 experienced no falls since admission/ readmission or prior assessment. Upon clinical review, Resident 4 experienced a fall on February 2, 2025, which was not reflected on the MDS dated [DATE]. A review of the clinical record indicated Resident 8 was admitted to the facility on [DATE], with diagnoses to include Monoplegia of the upper limb (one limb, an arm or a leg, has lost complete voluntary muscle movement). Further clinical record review revealed a quarterly MDS dated [DATE], for Resident 8, Section J, (section related to health conditions including fall history) documented Resident 8 did not experience any falls since admission/ readmission or prior assessment. Upon further clinical record review, Resident 8 experienced a fall May 4, 2025, which was not reflected on the June 24, 2025, quarterly MDS. An interview with the Director of Nursing and Nursing Home Administrator on September 11, 2025, at 11:10 AM confirmed the MDS coding for both Resident 4 and Resident 8 was inaccurate regarding fall history. 28 Pa. Code 211.5(f)(iii) Medical records. 28 Pa. Code 211.12(d)(1)(5) Nursing services.</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p>(continued on next page)</p>

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of select facility policy and clinical records, and staff interview, it was determined that the facility failed to develop and implement an individualized plan to meet the toileting needs of one of 18 sampled residents (Resident 5). Findings include: A review of facility policy titled 'Bowel & Bladder Toileting Plan' reviewed on February 27, 2025, revealed that all residents will be assessed on admission, readmission and change of condition according to the bowel and bladder patterning criteria. Upon completion of the assessment, individualized bowel and bladder program(s) will be initiated for each resident as indicated. A review of the policy titled 'Foley Catheter Procedure When a Resident is admitted With Foley in Place' describes a facility policy stating any resident who enters the facility with a catheter will be evaluated upon admission for the necessity of maintaining or removing the catheter. A review of Resident 5's clinical record revealed Resident 5 was admitted to the facility August 13, 2013, with diagnoses including lobar pneumonia (an infection causing inflammation of the air sacs in one or both lungs). A quarterly Minimum Data Set (MDS a federally mandated standardized assessment conducted at specific intervals to plan resident care), dated August 8, 2025, described Resident 5 as cognitively intact with a BIMS score of 13 (brief interview for mental status, a tool to assess the residents attention, orientation and ability to register and recall new information, a score of 13-15 indicates intact cognition). The assessment indicated Resident 5 required staff assistance for toileting hygiene and transfers. A review of the clinical record revealed Resident 5 returned to the facility on August 4, 2025, following an acute care stay from July 25, 2025, to August 4, 2025. Resident 5 returned with an indwelling catheter in place. Review of an MDS dated [DATE], showed that prior to hospitalization Resident 5 was incontinent and did not use an indwelling catheter (tube inserted into the bladder to drain urine). No documentation in the clinical record justified the presence of the catheter upon return from the hospital. Clinical records further indicated Resident 5 developed Moisture Associated Skin Damage (MASD inflammation and skin erosion caused by prolonged exposure to moisture such as urine or feces) on the right gluteal fold (the skin crease beneath the buttocks) and Incontinence Associated Dermatitis (a type of MASD caused specifically by urine exposure) upon return from acute care on August 4, 2025. The MASD was documented as measuring 14 cm in length by 8 cm in width. Further review of Resident 5's clinical record described the removal of the indwelling catheter on August 13, 2025. A review of the 72-hour resident voiding pattern illustrated Resident 5 had episodes of incontinence during the evaluation period from August 13, 2025, until August 16, 2025. Resident 5 was incontinent at 9:00 PM August 13, August 14, and August 15, 2025, according to the 72-hour resident voiding pattern record, which evaluated Resident 5's incontinence/ continence levels hourly. A review of the resident's person-centered care plan, initiated May 5, 2021, included focus areas for potential skin breakdown due to incontinence. A care plan revision on August 14, 2025, noted Resident 5's frequent incontinence and included goals for Resident 5 to remain free from skin breakdown. Interventions included two-hourly incontinence checks, cleansing, barrier cream, pull-up briefs per Resident 5's request, and monitoring for infection. However, the care plan did not specify the type of incontinence, did not include a structured toileting schedule, and did not incorporate individualized interventions targeted to the consistent 9:00 PM incontinence episodes documented in the voiding pattern record. A Bladder Review note dated August 19, 2025, documented Resident 5 was 100% incontinent since catheter removal, required assistance of two for transfers, and was at risk for incontinence related to diuretic use, difficulty walking, and muscle weakness. Despite these findings, there was no evidence of individualized interventions such as scheduled toileting times to reduce episodes of incontinence and support skin healing. There was no evidence the facility evaluated and implemented an individualized plan for Resident 5's toileting needs based on voiding patterns or habits, nor was there documentation to justify the presence of an indwelling catheter for nine days following return from acute care. An interview with the Director of Nursing and the Nursing Home Administrator on September 12, 2025, at 1:35 PM confirmed that the facility had not developed or implemented an individualized incontinence management plan for Resident 5. 28 Pa. Code 211.12 (d)(1)(3)(5) Nursing services. 28 Pa. Code 211.10(a)(d) Resident care policies.</p>		

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<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate pain management for a resident who requires such services.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of clinical records, select facility policy, and staff interviews, the facility failed to develop and implement an individualized pain management program consistent with professional standards of practice, including the use of non-pharmacological interventions prior to administering as-needed narcotic pain medication, and failed to follow physician orders for one of 22 residents reviewed (Resident 6). Findings include: According to the U.S. Department of Health and Human Services, Interagency Task Force, Pain Management Best Practices Final Report (May 6, 2021), effective pain treatment plans should be individualized and patient-centered, with measurable outcomes focusing on quality of life (QOL), improved functionality, and the ability to perform activities of daily living (ADL's basic self-care tasks such as bathing, dressing, eating, and toileting). Best practice emphasizes multimodal approaches (the use of multiple methods including medications, physical therapy, and other interventions) and recommends attempting non-pharmacological interventions (pain relief strategies that do not involve medication). These approaches are often the first step in pain management and are intended to reduce discomfort, improve function, and minimize the need for narcotics or other drugs. Examples include repositioning a resident, applying heat or cold, relaxation or breathing techniques, massage, distraction, exercise, or use of supportive devices such as pillows or braces) when clinically appropriate. A review of a facility policy last reviewed by the facility on February 27, 2025, revealed the physician will order appropriate non-pharmacologic and medication interventions to address a resident's pain. The policy further revealed non-pharmacological interventions will be attempted prior to the administration of PRN (as needed) pain medications. If non-pharmacological interventions failed, PRN narcotic medications could then be administered. The policy also required staff to use a verbal numeric pain scale (0 = no pain; 1-4 = mild pain; 5-7 = moderate pain; 8-10 = severe pain). A review of Resident 6's clinical record revealed the resident was admitted on [DATE], with diagnoses including osteoarthritis (most common form of arthritis when the protective cartilage that cushions the ends of the bones wears down over time and causes pain) of the right knee and muscle spasms. A physician order dated May 21, 2025, directed staff to administer Hydrocodone-acetaminophen 5/325 mg (a narcotic pain medication) by mouth every 6 hours as needed for moderate pain (pain scale 5-7). A review of the resident's May 2025 Medication Administration Record (MAR) revealed staff administered the PRN Hydrocodone five times. On all five occasions, staff documented no attempt of non-pharmacological interventions prior to administering the narcotic pain medication, contrary to facility policy. Further review of the May MAR revealed that on May 28, 2025, at 10:02 PM, staff administered the narcotic for a reported pain scale of 8 (severe pain), outside of the physician's order, which specified use only for moderate pain (5-7). A review of the June 2025 MAR revealed Hydrocodone was administered once. Again, no non-pharmacological interventions were documented prior to administration. A review of the July 2025 MAR revealed Hydrocodone was administered three times, each without documented use of non-pharmacological interventions. On July 6, 2025, at 5:37 PM, Hydrocodone was administered for a pain scale of 3 (mild pain). On July 13, 2025, at 4:50 PM, Hydrocodone was administered for a pain scale of 4 (mild pain). Both administrations were inconsistent with the physician's order, which required moderate pain (5-7) before administration. A review of the August 2025 MAR revealed Hydrocodone was administered once again without documentation of attempted non-pharmacological interventions. An interview with the Director of Nursing (DON) on September 12, 2025, at 11:10 AM confirmed that the facility was unable to provide documentation showing that staff attempted non-pharmacological interventions before narcotic administration or justification for administering the narcotic medication outside the parameters of the physician's order. 28 Pa. Code 211.10 (C)(d) Resident care policies. 28 Pa. Code 211.12 (d)(1)(3)(5) Nursing services.</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>Based on review of select facility policy, controlled drug records, clinical records, and staff interviews, it was determined the facility failed to implement procedures to promote accurate controlled drug records and failed to implement pharmacy procedures for timely disposition of resident medications to prevent misuse, diversion (unauthorized use or theft), or accidental exposure for one of three closed records reviewed (Resident 93). Findings include: Review of facility policy entitled, Disposition of Medications last reviewed by the facility on February 27, 2025, revealed guidance regarding disposition of medications. The policy explained a process to implement safe and responsible disposition practices of discontinued medications to protect residents and staff from improper diversion or accidental exposure. Further it is indicated medications discontinued by the prescriber order, residents' death, or discharge are either to be destroyed on site or return to the pharmacy for destruction. Controlled substances must be destroyed in the facility using the drug disposal system containing the instant chemical digestion solution. Review of clinical record for Resident 93, revealed the resident was discharged to the hospital on July 31, 2025, at 11:59PM with no anticipation of return. Review of a progress note dated July 31, 2025, at 11:39 PM revealed staff documented that two controlled substances, Tramadol (a narcotic pain medication) and Diazepam (a controlled anxiety medication), were secured in the Director of Nursing's (DON) office. The note indicated 39 Tramadol tablets, and 38 Diazepam tablets were placed in the DON's office. Review of the controlled substance log revealed the medications were destroyed by the DON on August 19, 2025, indicating the medications were stored in the DON's office for 20 days prior to proper disposition. Observation of the DON's office revealed a locker designated for controlled substance storage. The locker had one lock with only one key, which was in the possession of the DON. An interview with the DON on September 11, 2025, at 12:30 PM revealed that when she was not available, staff placed controlled medications in her office, but staff did not have access to the locker. The interview further revealed that staff members had access to her office, creating an opportunity for staff to access controlled substances without appropriate oversight. The DON indicated she had been on vacation during the beginning of August, which left the Tramadol and Diazepam unsecured in her office for an extended period of time. The facility was unable to produce a narcotic log for the medications stored in the locker in the DON's office. The facility confirmed there was no plan in place for proper accounting of narcotics awaiting disposition. An interview with the Nursing Home Administrator (NHA) and the DON on September 12, 2025, at 2:30 PM confirmed the facility was unable to provide documentation of procedures to ensure accurate controlled drug records and timely disposition of resident medications. 28 Pa Code 211.10(c)(d) Resident care policies. 28 Pa Code 211.12 (c)(d)(1)(3)(5) Nursing services. 28 Pa Code 211.9(a)(1)(j.1)(1)(2)(3)(4)(5)(k) Pharmacy services.</p>		