STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395142	A. Building B. Wing	11/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Amoroso Healthcare and Rehabilitation Woodridge	3625 North Progress Ave Harrisburg, PA 17110

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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. (continued on next page)

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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, clinical record review, and staff interview, it was determined that the facility failed to provide and document sufficient preparation to residents to ensure a safe and orderly discharge from the facility; and failed to provide a discharge summary that included a post-discharge plan of care, including post-discharge services, for one of two discharged residents reviewed (Resident 1).Findings include:Review of facility policy, titled Discharge Summary and Plan, with a last review date of May 21, 2025, revealed, in part, 2. The discharge summary provides necessary information for continuing care providers pertaining to the course of treatment while the resident was in the facility and the resident's plans for care after discharge. 3. By the time the resident leaves the facility, the discharge summary is furnished to the provider who is assuming responsibility for care of the resident after discharge. 4. The discharge summary may be provided in printed or electronic format. If in electronic format, the receiving provider will acknowledge there is a way to receive and access the discharge summary electronically. 5. The medical record contains a copy of the discharge summary with the identity of the recipient of the summary. In addition, in the section titled Discharge Summary: 1. A discharge summary includes: a. a recapitulation of the resident's stay at the facility (a concise summary of the resident's stay and course of treatment in the facility); b. a final summary of the resident's status at the time of the discharge available for release to authorized individuals and agencies, with the consent of the resident or representative.In section titled Discharge Planning: 1. Every resident has an individualized discharge plan, which begins at admission and is part of the comprehensive care plan. 2. The purpose of the discharge plan is to ensure a safe transition from the facility to the post-discharge setting. 3. The discharge plan is developed by the care planning/ interdisciplinary team with the assistance of the resident and the representative to develop interventions to meet the resident's discharge goals and needs that must be addressed before the resident can be safely discharged (e.g., caregiver support and education, rehabilitation, etc.). 4. The discharge plan is based on the resident assessment, the goals for care, the desire for discharge and the resident's capacity for discharge. 5. Discharge planning identifies the discharge destination, and ensures that it meets the resident's health and safety needs, as well as preferences. 7. A member of the IDT reviews the final discharge plan with the resident and family at least twenty-four (24) hours before the discharge is to take place. 8. The final discharge plan of care shows what arrangements have been made for the resident regarding: a. where the resident will live after leaving the facility; b. follow-up care the resident will receive from other providers, and that provider's contact information; c. needed medical and non-medical services (including medical equipment); d. community care and support services, if needed; and e. when and how to contact the continuing care provider.In section titled Discharge to the Community: 3. The facility makes referrals to local agencies, the local ombudsman, and support services that can assist in accommodating the resident's post-discharge preferences, as appropriate. Referrals made for this purpose, and the response to these referrals, are documented in the medical record. Review of Resident 1's clinical record revealed that she was admitted to the facility on [DATE], with diagnoses that included atrial fibrillation (an irregular, often rapid heart rate that commonly causes poor blood flow), dementia with behavioral disturbance (cognitive decline accompanied by significant changes in behavior), repeated falls, and generalized muscle weakness.Further review of Resident 1's clinical record revealed that she was discharged home on October 2, 2025.Review of Resident 1's physician orders revealed an order, dated October 2, 2025, for Home Health upon discharge for physical therapy and occupational therapy. Review of Resident 1's care plan revealed a care plan focus for: chronic/ progressive decline in intellectual functioning characterized by deficit in memory, judgment, decision making and thought process related to dementia; impaired visual function; communication problem related to hearing deficit; activities of daily living self care performance deficit; limited physical mobility; at risk for falls; and Resident wishes to discharge back to the community, all with an initiated date of September 20, 2025. Review of Resident 1's progress notes revealed a physician's history and physical note dated September 14, 2025, at 5:45 PM, that indicated in the Assessment and Plan section that Resident 1 had a fall prior to admission that resulted in facial injuries; that physical therapy would work on balance and transfers; and that she needed 24-hour support secondary to her diagnosis of dementia. Review of Resident 1's progress notes revealed a note dated September 16, 2025, at 2:37 PM, by the Nursing Home Administrator (NHA) that indicated he had met with Resident 1 and that her friend participated by phone. The note further indicated that Resident 1 was

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, clinical record review, and staff interview, it was determined that the facility failed to provide sufficient and timely social services related to the admission and discharge planning process for one of two residents reviewed (Resident 1).Findings include:Review of facility policy, titled Social Assessment, with a last review date of May 21,2025, revealed, in part, A social assessment shall be completed within fourteen (14) days of the resident's admission to the facility. A social assessment will be done to help identify the resident's personal and social situation, needs, and problems. Social services staff will obtain information during the initial interview of the family and upon the resident's admission. The purpose of obtaining this data is to identify information to help staff develop a personalized plan of care that will utilize the individual ' s existing strengths, try to compensate for physical and functional deficits, optimize function and quality of life, and meet the individual ' s needs and preferences.Review of facility policy, titled Social Services, with a last review date of May 21,2025, revealed, in part, The director of social services is a qualified social worker and is responsible for maintaining records related to social services and meeting or assisting with the medically-related social service needs of residents. The social worker/social services staff are responsible for assisting with informing and educating residents, families and representatives about health care options, making referrals and obtaining needed services from outside entities, helping residents with transitions of care services (for example, community placement options, home care services, transfer arrangements, etc.), and identifying and seeking ways to support resident needs through the assessment and care planning process.Review of facility policy, titled Discharge Summary and Plan, with a last review date of May 21, 2025, revealed, in part, Discharge Planning: 1. Every resident has an individualized discharge plan, which begins at admission and is part of the comprehensive care plan. 2. The purpose of the discharge plan is to ensure a safe transition from the facility to the post-discharge setting. 3. The discharge plan is developed by the care planning/ interdisciplinary team with the assistance of the resident and the representative to develop interventions to meet the resident ' s discharge goals and needs that must be addressed before the resident can be safely discharged (e.g., caregiver support and education, rehabilitation, etc.). 4. The discharge plan is based on the resident assessment, the goals for care, the desire for discharge and the resident's capacity for discharge. 5. Discharge planning identifies the discharge destination, and ensures that it meets the resident's health and safety needs, as well as preferences. 7. A member of the IDT {interdisciplinary team} reviews the final discharge plan with the resident and family at least twenty-four (24) hours before the discharge is to take place. 8. The final discharge plan of care shows what arrangements have been made for the resident regarding: a. where the resident will live after leaving the facility; b. follow-up care the resident will receive from other providers, and that provider's contact information; c. needed medical and non-medical services (including medical equipment); d. community care and support services, if needed; and e. when and how to contact the continuing care provider. In section titled Discharge to the Community: 3. The facility makes referrals to local agencies, the local ombudsman, and support services that can assist in accommodating the resident's post-discharge preferences, as appropriate. Referrals made for this purpose, and the response to these referrals, are documented in the medical record.Review of Resident 1's clinical record revealed that she was admitted to the facility on [DATE], with diagnoses that included atrial fibrillation (an irregular, often rapid heart rate that commonly causes poor blood flow), dementia with behavioral disturbance (cognitive decline accompanied by significant changes in behavior), repeated falls, and generalized muscle weakness. Further review of Resident 1's clinical record revealed that she was discharged home on October 2, 2025. Review of Resident 1's Social Services Evaluation-admission dated September 12, 2025, revealed it was blank. Further review of Resident 1's clinical record failed to reveal any documented social service assessments. Review of Resident 1's care plan revealed a care plan focus for: chronic/progressive decline in intellectual functioning characterized by deficit in memory, judgment, decision making and thought process related to dementia; impaired visual function; communication problem related to hearing deficit; activities of daily living self-care performance deficit; limited physical mobility; at risk for falls; and Resident wishes to discharge back to the community, all with an initiated date of September 20, 2025. Review of Resident 1's progress notes revealed a physician's history and physical note dated September 14, 2025, at 5:45 PM, that indicated in the Assessment and Plan section that Resident 1 had a fall prior to admission that resulted in facial injuries; that physical therapy would work on balance and transfers; and that she needed 24-hour