

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: 395173	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/14/2026
NAME OF PROVIDER OR SUPPLIER Westgate Hills Rehabilitation and Nursing Ctr		STREET ADDRESS, CITY, STATE, ZIP CODE 2050 Old West Chester Pike Havertown, PA 19083	
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 observations and staff interviews, it was determined that the facility failed to properly store food and maintain sanitary conditions and failed to properly label and date food products in the Main Kitchen which created the potential for cross contamination. Findings include: During an observation of the main kitchen on January 11, 2025, at 9:10 a.m. the following was observed: - Dry Storage: three packets of crackers on the floor, one maple syrup container on the floor, one used rubber glove on the floor, one open bag of pasta which also lacked proper dating and labeling, and one box containing 24 Glucerna Shakes on the floor -Walk in freezer- one open bag of chicken patties that was not sealed and missing appropriate date and label -Walk-in refrigerator- two open bags of bread missing a used by date and label -Prep refrigerator- one bag of sliced cheese missing appropriate date and label. Interview conducted with the Kitchen Manager on January 11, 2026, at 9:40 a.m. confirmed that all open bags and containers should have been properly sealed and contain a used by date and labeled. During an interview on January 14, 2025, at 1:15 p.m. Nursing Home Administrator (NHA) confirmed that the facility failed properly store food and maintain sanitary conditions and properly label and date food products in the main kitchen which created the potential for food borne illness. 28 Pa. Code: 201.18(b)(1) Management. 28 Pa. Code: 211.6(c) Dietary services. 28 Pa. Code: 201.14(a) Responsibility of licensee.		

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical records, observations, and staff interviews, it was determined that the facility failed to protect the residents' rights for two of 32 residents reviewed (Resident R31 and R43). Findings include: Resident R31 was admitted to the facility on [DATE], with the following diagnosis: hemiplegia and hemiparesis following cerebral infarction affecting right dominant side (stroke and complete paralysis of right side), muscle wasting and atrophy, not elsewhere classified, multiple sites, and difficulty in walking, not elsewhere classified. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident R31, dated December 25, 2025, revealed that the resident required supervision or touching assistance for upper body dressing and substantial/maximal assistance for lower body dressing. An interview conducted with Resident R31 on January 11, 2025, at 10:23 a.m. revealed Resident R32 was waiting on staff assistance to change out of her hospital gown and into clothing the resident had picked out. Observations conducted of Resident R31 on January 11, 2025, at 12:00 p.m., 1:15 p.m. and 2:02 p.m. revealed Resident R31 was still in her hospital gown and waiting for staff to assist her in changing. An interview conducted with the Director of Nursing (DON) and the Nursing Home Administrator (NHA) on January 14, 2025, at 1:13 p.m. confirmed that nursing staff should have assisted Resident R31 in changing from her hospital gown into appropriate personal clothing. The failure to provide timely assistance limited the residents' right to be treated with dignity and respect. Resident 43 was admitted to the facility on [DATE], with medical diagnoses that include Lack of Coordination, Abnormalities of Gait and Mobility, (unusual walking patterns and movement disorders that can affect balance and coordination), Muscle Wasting and Atrophy (loss of muscle mass or strength), Muscle Weakness and Intervertebral Disc Degeneration Lumbar Region (breakdown of discs that cushion the vertebrae in the lower back leading to pain and discomfort). A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 43, dated December 21, 2025, revealed that the resident required set up or clean up assistance with eating. Review of Resident 43's care plan revealed a focus dated September 18, 2018, noting the resident requires assistance with his activities of daily living (adls) related to fatigue, impaired balance, and limited mobility. Interventions included Eating: the resident feeds self independently set up assist as needed, last revised May 20, 2021. Review of Resident 43's Occupational Therapy (OT) Discharge summary dated [DATE], revealed on December 4, 2025, the resident's eating baseline was partial to moderate assistance to scoop food and perform hand to mouth during self-feeding. (continued on next page)		

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review of Resident 43's OT discharge summary revealed the resident was discharged from therapy on December 21, 2025, requiring supervision or touch assistance for scooping food and performing hand to mouth during self-feeding. Observations made of breakfast service, in the 2nd floor dining room, on January 11, 2025, at 9:35 a.m., revealed Nurse Aide Employee E4 standing over Resident 43, feeding him/her breakfast. Observations made of lunch service, in the 2nd floor dining room, on January 11, 2025, at 1:10 p.m., revealed Employee E4 again standing over Resident 43, feeding him/her lunch. Observations made on January 12, 2025, at 9:09 a.m., revealed Resident 43 attempting to feed him/herself in bed, oatmeal and coffee were observed on the resident's tray, bed table and hospital gown. The resident was observed attempting to drink coffee from a cup which still had a lid on it. The coffee was observed leaking from the cup onto the resident's chest. Interview conducted with Nursing Home Administrator (NHA) and Director of Nursing (DON) on December 13, 2025, at 1:47 p.m., when the above information was presented, the DON stated the reason Employee E4 was standing while feeding Resident 43 was because Employee E4 has a medical condition involving his/her knees which prohibits him/her from sitting for long periods of time. Employee E4 standing while feeding Resident 43 limited the resident's right to be treated with dignity and respect. 28 Pa. Code 201.29(j) Resident Rights.		

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. Based on clinical records review and staff interviews, it was determined that the facility failed to follow physician orders regarding administration of nutrition for one of three residents reviewed (Resident 11). Findings include: Review of Resident 11's diagnosis list revealed, nutritional deficiency unspecified (inadequate supply of essential nutrients in the diet which can lead to malnutrition or disease) and huntington's disease (inherited genetic condition that causes the general breakdown of nerve cells in the brain). Review of Resident 11's physicians order revealed an order dated October 17, 2025, for Enteral Feed Order one time a day for Feeding Continuous Tube Feeding: Product: Jevity 1.5 At 65 ML/ Hour via peg tube. Up at: 1600 Down when total volume of 1300MLs have been infused. Total Calories: 1950 kcal. Review of Resident 11's medication administration record (MAR) for October and November 2025 revealed Resident 11 received a total Jevity 1.5 volume on October 1-1000ml; October 8 no amount recorded; October- 11, 13, 14 900ml; October 15-820ml; November 18-839ml and November 25-607ml. The facility failed to ensure Resident 11's physician order regarding continuous tube feeding for the total volume of 1300 ml was followed. Interview with licensed Director of Nursing on January 14,2026 at approximately 12:30pm confirmed that tube feeding order was not being documented correctly. 28 Pa. Code 211.5(f) Clinical Records 28 Pa. Code 211.12(d)(1)(3)(5) Nursing Services		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on policy reviews, clinical records review and staff interviews, it was determined that the facility failed to develop physician orders regarding respiratory care for 1 of eight resident's reviewed (Resident 2). Findings include: Review of Resident 2's face sheet revealed medical diagnoses that include Nontraumatic Intracerebral Hemorrhage in Hemisphere Subcortical (spontaneous bleeding within brain tissue), Acute Respiratory Failure with Hypoxia (sudden inability of lungs to provide adequate oxygen to blood), and Tracheostomy Status, (surgical procedure that creates an opening in the neck to facilitate breathing when the usual airway is obstructed or compromised). Review of facility policy titled Tracheostomy Care, last revised January 2, 2026, revealed compliance guidelines noting the facility will provide necessary respiratory care and services, such as oxygen therapy, treatments, mechanical ventilation, tracheostomy care and/or suctioning. Review of Resident 2's physician orders failed to reveal orders for oxygen therapy including method of administration, volume to be administered, or frequency of administration. The policy further notes that based on the resident's assessment, attending physician orders, and professional standards of practice, the facility in collaboration with the resident/resident representative will develop a care plan that includes appropriate interventions for respiratory care. Review of Resident 2's care plan revealed a focus dated December 24, 2025, noting the resident has a tracheostomy related to impaired breathing mechanics. Interventions included administer humidified oxygen as prescribed. Further review of Resident 2's care plan revealed a focus dated December 24, 2025, noting the resident has altered respiratory status/difficulty breathing related to. No information was provided concerning what Resident 2's respiratory status/difficulty breathing was related to. Interventions included oxygen (O2) settings: O2 via (specify nasal prongs/mask) no specifications were noted, at (specify) liters (L), no specifications were noted, (specify frequency) no specifications were noted, and humidified (specify) no specifications were noted. Observations of Resident 2 on January 14, 2025, at 10:30 a.m., revealed the resident was receiving oxygen via the tracheostomy tubing, the oxygen concentrator (a medical device used to filter and concentrate oxygen obtained from the environment) was set to 6 lpm (liters per minute), and the pressure pump (device used to supply oxygen under pressure) was set to level 5. Interview with Director of Nursing (DON) on January 14, 2025, at 11:05 a.m. when the above information was presented, the DON stated the resident did not have physician orders for oxygen care because the resident was on room oxygen. 28 Pa. Code 211.5(f) Clinical Records 28 Pa. Code 211.12(d)(1)(3)(5) Nursing Services		

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. Based on observations, clinical records review and interview with staff, it was determined that the facility failed to ensure fluid restriction orders for dialysis residents were followed for one of one dialysis resident reviewed. (Residents 55). Finding include: A review of the facility's policy titled Fluid Restriction, dated 1/1/26, revealed the following guidelines for restricting fluids: The nurse in collaboration with the dietician will obtain and verify the physician's order for the fluid restriction and an order written to breakdown include the breakdown of the amount of fluid per 24 hours to be distributed between the food and nutrition department and the nursing department and will be recorded in the medical record. Review of Resident 55's diagnosis list includes End Stage Renal Failure (ESRD- failure of kidney function to remove toxins from blood), and dependence on renal Hemodialysis (A process of purifying the blood of a person whose kidneys are not working normally). Review of Resident physician's orders dated December 16,2025 revealed an order for daily Fluid restriction: 2000ML/day:1000ml dietary, 1000ml nsg. Dietary 420ml breakfast, 420ml lunch, 180ml dinner. Nursing:420ml 7-3 shift, 460ml 3-11 shift,120ml 11-7 shift. Review of Resident 55's Medical Administration Record (MAR) failed to reveal evidence of the amount of fluid Resident 55 was receiving each shift. Interview with Employee 3 on January 13, 2026, at approximately 2:13pm confirmed the above findings. 28 Pa. Code: 211.5(f) Clinical records 28 Pa. Code 211.12(d)(1)(5) Nursing Service		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. Based on facility policy review, observations, and staff interview it was determined the facility failed to label and store medications in accordance with currently accepted professional principles for 2 out of 3 medication carts reviewed. (1st and 2nd floor back hallway medications carts) Findings include: Review of facility policy (undated), titled: Medications with Shortened Expiration Dates revealed all eye drops must be dated upon opening and discarded 3 months after opening unless they have a shortened expiration date. Observation of the 2nd floor back hall med cart on January 13, 2026 at 9:45 a.m. revealed, Open Redness Reliever eye drops (saline eye drops) undated open Artificial Tears (saline eye drops) dated 8/26/2025 and open Artificial Tears dated 8/31/2025. A review of the 1st floor back hall medication cart on January 13, 2026 at 10:00 a.m. was observed to be unlocked and standing out in front of a resident's room at the end of the hall. When staff came out of the resident's room, they were asked who was responsible for the med cart. They replied that they were not the nurse on the unit, but they would get the nurse. The staff proceeded to go up the hallway to the nurses' station to call the nurse. Interview with Licensed Nursing Employee E6 on January 13, 2026 at 10:05 a.m. revealed that she was assigned to the med cart and confirmed it was unlocked and the medications were unsecure. 28 Pa. Code 211.12(c)(d)(1)(3)(5) Nursing Services		

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or get specialized rehabilitative services as required for a resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and staff interview it was determined the facility failed to provide specialized speech therapy services as determined in their comprehensive care plan for 1 out of 1 resident reviewed. (Resident 29) Findings include: Review of Resident 29's diagnosis list revealed the resident was admitted to the facility on [DATE] with traumatic hemorrhage of right cerebrum with loss of consciousness (a type of stroke that causes bleeding in the skull), aphasia (difficulty speaking caused by damage to the brain) and dysphagia (difficulty swallowing that can be caused by a stroke) and feeding tube (a feeding tube placed in the stomach) that was placed during her stay in the hospital, and she is receiving 100% nutritional needs through her feeding tube. Review of Resident 29's care plan dated December 15, 2025 revealed an intervention of Skilled ST (speech therapy) services as ordered for strengthening and PO (by mouth) trials to improve oropharyngeal (swallowing) function and ability to tolerate least restrictive diet. Review of Resident 29's orders revealed an order dated December 15, 2025 for speech therapy 4-5 times per week. Review of speech therapy records reveal that Resident 29 received an evaluation by an SLP (Speech Language Pathologist) on December 15, 2025 and received speech therapy on December 17, 2025, December 19, 2025, and December 21, 2025. Resident 29's next speech therapy session was December 31, 2025. An interview with the E5 (Director of Rehab Services) on January 14, 2026 at approximately 12:15 p.m. revealed the resident should have received therapy on December 24, 2025, but she was attending a holiday event within the facility, and the speech therapist did not want to interrupt her activity. Interview with E5 also revealed they did not have a full time SLP on staff because their full time SLP was on a planned leave and there was a part-time SLP filling in from their corporate office. 28 Pa. Code: 211.12 (d)(1)(3)(5) Nursing services		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of clinical records, observation and staff interview, it was determined the facility failed to maintain accurate and complete clinical records for one out of 8 residents reviewed. (Residents R31) Findings included: The Pennsylvania Code, Title 49, Professional and Vocational Standards, State Board of Nursing, 21.145 Functions of the Licensed Practical Nurse (LPN) (a) The LPN is prepared to function as a member of the health-care team by exercising sound judgement based on preparation, knowledge, skills, understandings, and past experiences in nursing situations. The LPN participates in the planning, implementation, and evaluation of nursing care in settings where nursing takes place. 21.148 Standards of nursing conduct (a) A licensed practical nurse shall: (5) Document and maintain accurate records. According to the American Nurses Association Principles for Nursing Documentation, nurses document their work and outcomes and provide an integrated, real-time method of informing the health care team about the patient status. Timely documentation of the following types of information should be made and maintained in a patient's EHR (electronic health record) to support the ability of the health care team to ensure informed decisions and high-quality care in the continuity of patient care: Assessments Clinical problems Communications with other health care professionals regarding the patient Communication with and education of the patient, family, and the patient's designated support person and other third parties. Resident R31 was admitted to the facility on [DATE], with the following diagnosis: hemiplegia and hemiparesis following cerebral infarction affecting right dominant side (stroke and complete paralysis of right side), muscle wasting and atrophy, not elsewhere classified, multiple sites, and difficulty in walking, not elsewhere classified. Review of Resident R31's clinical medical record revealed an active order for lidocaine pain relief external patch 4 % (lidocaine) apply to right shoulder topically one time a day for right shoulder pain 12 hours on/12 hours off and remove per schedule. With a start date of January 7, 2025. A review of Resident R31's Medication Administration Record (MAR) revealed the above medication was documented as administered on January 11, 2025, at 9:00 a.m. However, during an interview conducted with Resident R31 on January 11, 2025, at 10:23 a.m., the resident stated she refused the lidocaine pain relief patch because she was not experiencing pain. Observations of Resident R31's right shoulder at that time confirmed the resident did not have a lidocaine patch in place. An interview conducted with the Nursing Home Administrator (NHA) and Director of Nursing (DON) on January 11, 2025, at 1:15 p.m. confirmed that nursing staff inaccurately documented the administration of Resident R31's lidocaine pain relief patch on the Medication Administration Record (MAR) despite the resident's refusal of the medication. This documentation error resulted in an inaccurate medical record that failed to accurately reflect Resident R31's medication administration status. 28 Pa. Code 211.12 (c)(d)(1)(5) Nursing Services 28 Pa. Code 211.5 (f) Medical records		