

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: 395193	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/08/2025
NAME OF PROVIDER OR SUPPLIER Rosemont Center		STREET ADDRESS, CITY, STATE, ZIP CODE 35 Rosemont Avenue Rosemont, PA 19010	
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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interviews and review of clinical records, it was determined that the facility failed to conduct a complete and thorough investigation to rule out abuse/neglect for 4 of 17 residents reviewed (Resident R1, R2, R23 and R51). Findings Include: Review of facility policy Abuse Prevention Program reviewed November 30, 2022, revealed all reports of resident abuse, neglect, mistreatment and/or injuries of unknown source shall be thoroughly investigated by facility management. The individual conducting the investigation will include, but not be limited to, interview any witnesses to the incident and interview staff members (on all shifts) who have had contact with the resident during the period of the alleged incident. The facility administration will protect our residents from abuse by anyone including, but not necessarily limited to facility staff, other residents, consultants, volunteers, staff from other agencies, family members. The facility will investigate and report any allegations of abuse within timeframes as required by federal and state requirements; protect residents during abuse investigations. Continued review of the policy indicated that for resident-resident altercations all altercations including those that represent resident-to-resident abuse shall be investigated and reported to the nursing supervisor, the director of nursing, the administrator and applicable regulatory agencies. Review of Resident R2's quarterly Minimum Data Set (MDS - federally mandated resident assessment and care screening) dated March 19, 2025, revealed the resident was admitted to the facility on [DATE], and had diagnoses of neurogenic bladder (a condition when neurological conditions causes one to lose bladder control), lack of coordination, and stage 2 pressure ulcer (characterized by partial-thickness skin loss, presenting as a shallow, open wound or blister) of the right buttock. Review of Resident R2's comprehensive care plan dated January 30, 2025, revealed the resident was at risk for skin breakdown related to decreased mobility, fragile skin, refusal of showers, and bowel/bladder incontinence. Review of Resident R2's wound consultation dated March 24, 2025, revealed the resident was seen for an initial consultation for wound services. Continued review of the wound consultation dated March 24, 2025, revealed Resident R2 was evaluated and treated for a stage II pressure ulcer on the left buttock. Review of Resident R2's wound consultation dated April 1, 2025, revealed upon examination the stage II (ulcer involving loss of the top layers of the skin) pressure ulcer of the left buttock showed complete epithelization (formation of a new layer of skin over the wound) with no signs of infection or inflammation. The wound report indicated that the wound healing was complete, and the wound was fully closed. Review of Resident R2's clinical record revealed Licensed Nurse, Employee E7, documented an existing skin issue on a skin check assessment dated [DATE]. Further review of the skin check assessment dated [DATE], revealed location and description of the skin issue was left blank. Continued review of Resident R2's clinical record revealed a nursing note dated April 7, 2025, that revealed during Resident R2's weekly shower a skin issue was identified on the resident's sacrum. The area was described as having sanguineous drainage (leakage of fresh blood from a wound). Review of Resident R2's clinical record revealed a wound consultation dated April 8, 2025, that the resident was seen for a re-consultation visit for wound care services. Continued review of the wound consultation dated April 8, 2025, revealed Resident R2 was evaluated and treated for an unstageable pressure ulcer on the left buttock. (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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on September 4, 2025, at 12:50 p.m. with Director of Nursing, Employee E2, revealed no investigation or incident report was available for the new wound identified on April 7, 2025. Continued interview with the Director of Nursing, Employee E2, revealed no statement was available from Licensed Nurse, Employee E7, regarding the documentation on the skin check assessment dated [DATE]. Review of the August 2025 physician orders for Resident R51 revealed the diagnoses of schizoaffective disorder (a mental health condition that is marked by a mix of schizophrenia symptoms, such as see things and hearing voices and believing things that are not real or true, and mood disorder symptoms; anxiety (intense, excessive and persistent worry and fear about everyday situations); adjustment disorder (a mental health condition characterized by an excessive emotional or behavioral response to a significant life stressor, leading to distress and functional impairment); hypertension (high blood pressure); muscle weakness, and hyperlipidemia (high cholesterol).Review of the resident's quarterly Minimum Data Set Assessment (MDS- a periodic assessment of a resident's needs) dated May 2, 2025 indicated that the resident cognitive intact.Review of the September 2025 physician orders for Resident R23 revealed the diagnoses of psychosis; bipolar; schizophrenia; dementia; unspecific pain; cataracts; cognitive communication deficit and anxiety. Continued review of the September 2025 physician orders indicated that Resident 23 had a physician's order dated March 27, 2025 and monthly thereafter for the resident to wear a wanderguard (a system used to prevent residents with a tendency to wander from leaving monitored areas) to his left ankle.Review of the resident's person-centered plan of care included a plan of care dated July 7, 2022 for the behavior of wandering the halls and going into other resident rooms. Interventions included re-directing the resident as needed for behavioral episodes.Review of the resident's quarterly MDS dated [DATE] indicated that the resident was cognitively impaired.Review of a nursing note dated May 22, 2025 at 2:53 a.m. documented that Employee E10 (licensed nurse) Resident R23 had very aggressive and had to be redirected by staff. The note also documented that the resident was seen going to room [ROOM NUMBER]A multiple times and that Resident R51 got upset and threw a trashcan at Resident R23, directing him to get out of her room. Resident with very aggressive behavior hard to redirect by staff. Resident going to room [ROOM NUMBER]A multiple times. Resident in room [ROOM NUMBER]A was upset throw the trash can to him screaming Get out of my room and c/o (complaint) about [Name of Resident] going to her room. Resident also noted going to the elevator. Resident with wanderguard in placed. Will give report to incoming Nurse. Resident refused to go to his room. Resident is sitting at the nurses station for close monitoring. Will continue to monitor. Snack was given to resident.Review of a nursing note dated May 22, 2025 at 2:00 p.m. documented that Employee E13 (licensed nurse) observed Resident R51 hitting Resident R23 with a trash can. Resident R23 reported to the nurse that he did not know why Resident R51 hit him with the trash can. this nurse was exiting room [ROOM NUMBER] when i observed the other resident hitting this resident with a trash can at the back of his head. this resident stated he is unsure of why other resident hit him with the trash can. This nurse removed resident from hallway into the lounge area. nurse did a skin check to head, no skin issues present. pain assessed as well, no pain. md (physician) . notified upon arrival facility. nurse tried to contact the contacts on file for resident, no answer. nursing sup (supervisor)/adon (assistant director of nursing) notified.Review of the clinical record did not show evidence of a complete and through investigation that was conducted to prevent further incidents from occurring between the residents during the investigation.During an interview with the Director of Nursing (DON) on September 8, 2025 at 11:21 a.m. the DON reported that she was aware of the above referenced incident and confirmed during the interview that the facility did not complete an investigation for the above two referenced incidents related to allegations of resident-to-resident abuse.Review of the September 2025 physician orders for Resident R1 revealed diagnosis that included anxiety (intense, excessive and persistent worry and fear about everyday situations); depression (a mood disorder that may be described as feelings of sadness, loss, or anger that interfere with a person's everyday activities); cerebral vascular disease (a group of disorders that (continued on next page)		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	affect blood flow to the brain, leading to conditions such as stroke, aneurysms, and vascular malformations); dysphagia (difficulty swallowing)d and unspecified pain.Review of a quarterly Minimum Data Set Assessment (MDS- periodic assessment of a resident's needs) dated December 13, 2024, indicated that the resident was awake, alert and oriented.Review of a nursing note for Resident R51 dated December 10, 2024 at 11:28 a.m. indicated that Employee E7 (licensed nurse) reported that on December 9, 2025, the facility's occupational therapist reported to the charge nurse that Resident R1 was self medicating himself in Resident R51's room, and that upon entering the room the charge nurse (Employee E7) found a pill on Resident R51's end table but Resident R51 reported that she did not know where it came from. Licensed nurse also documented that on December 10, 2024 Resident R51 told the facility's activity staff that she gave Resident R1 medication for a head ache. OT overserved the resident's roommate [NAME OF RESIDENT] attempting to self-medicate himself she then notifies the charge nurse upon entering the room the charge nurse found a pill on the resident end table when question by the charge nurse the resident stated that she doesn't know where it came from. 12/10/24 the resident told activities that she gave it to the resident for a headache the charge nurse then educated the resident that she cannot self-medicate herself nor another resident and that if she has any more medication, she should turn them over to the nurse. Resident stated that she understands and that she did not give any medication to the resident.Review of the clinical record did not show evidence of a complete and through investigation that was conducted to prevent further ingestions of unknown substances from occurring during the investigation, and to ensure that appropriate corrective actions were taken.During an interview with the Director of Nursing (DON) on September 8, 2025 at 11:22 a.m. the DON reported that she was aware of the above referenced incident and confirmed during the interview that the facility did not complete an investigation for the above referenced incident of allegations on unknown substances in Resident R1 and Resident R51 possession that may have been ingested. 28 Pa. Code 201.14 (a) Responsibility of licensee28 Pa. Code 201.29 (a) Resident rights		

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep all essential equipment working safely. Based on review of facility policy, observations, and staff interviews it was determined that the facility failed to ensure kitchen equipment was maintained in safe and operating condition (Main Kitchen). Findings Include: Review of undated facility policy Pot and Pan Washing revealed proper pot and pan washing procedures reduce the possibility of food contamination. Review of facility policy revealed pots and pans will be washed in the first sink, rinsed in the second sink, and sanitized in the third sink. Pots and pans are sanitized using warm water and bleach or sanitizer to provide no less than 50 PPM chlorine in solution for one minute. An initial tour of the main kitchen was conducted on September 2, 2025, at 9:00 a.m. with Food Service Director, Employee E6. During a tour of the kitchen, a dietary aide was observed to be utilizing the 3-compartment sink to wash pots and pans. The third compartment of the 3-compartment sink was identified as the sanitizing sink. The Food Service Director, Employee E6, used a chlorine test strip to monitor the sanitizing solution of the water. The test strip resulted < 50 ppm chlorine, indicating that there was not a sufficient amount chlorine solution to properly sanitize. Observations during testing of the sanitizing sink revealed the faucet had a constant stream of water pouring into the sanitizing sink. Interview with the Food Service Director, Employee E6, revealed that the faucet was broken and could not be turned off causing the sanitizing solution to be diluted. Interview on September 2, 2025, at 2:37 p.m. with Food Service Director, Employee E6, revealed the sink faucet has been broken since end of last month and that staff need to frequently check the level of sanitizing solution while using the 3-compartment sink and add extra sanitizer as needed to compensate for the broken faucet diluting the solution. 28 Pa. Code 201.14 (a) Responsibility of licensee.		

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F 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to share a room with spouse or roommate of choice and receive written notice before a change is made. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interviews and the review of clinical records, it was determined that the facility failed to ensure that written notification was received prior to a resident's room change for 1 out of 17 residents reviewed (Resident R1). Review of Resident R1's September 2025 physician orders revealed the diagnoses of anxiety (intense, excessive and persistent worry and fear about everyday situations); depression (a mood disorder that may be described as feelings of sadness, loss, or anger that interfere with a person's everyday activities); cerebral vascular disease (a group of disorders that affect blood flow to the brain, leading to conditions such as stroke, aneurysms, and vascular malformations); dysphagia (difficulty swallowing) and unspecified pain. Review of a Quarterly Minimum Data Set Assessment (MDS- periodic assessment of a resident's needs) dated December 13, 2024 indicated that the resident was cognitive intact. Review of the facility policy, Room Change/Roommate Assignment, revised September 2017, indicated that the facility reserves the right to make resident room changes or roommate assignments when the facility deems it necessary or when the resident requests the change. The policy also indicated that prior to changing a room or roommate assignment all parties involved in the change/assignment (e.g., residents and their representatives (sponsors) will be given a _____ (no specific time indicated in the policy) hour/day advance notice of such change, and that advance notice of a roommate change will include why the change is being made, in addition to any information that will assist the roommate in becoming acquainted with his or her new roommate. Continued review of the policy indicated that unless medically necessary or for the safety and well-being of the resident(s), a resident will be provided with an advance notice of the room change and that such notice will include the reason(s) why the move is recommended. Review of a nursing note dated December 9, 2025 at 11:26 p.m. indicated that that resident's room was changed. Day 1/3: Resident transferred from 2nd floor to RM [ROOM NUMBER]C with schedule medications and belongings. Alert and oriented. No s/s of distress. Tolerated all Po (by mouth) meds. Staff assisted with adls (activities of daily living). Adjusting to new room and roommate. Safety precautions in place. Bed in lowest position with call bell within reach. Continued review of the facility's room change notification (an in house form used to document the date of the room change, person notified, and the reason for the room change) dated December 9, 2025 indicated that that the room change was due to safety reasons and that the resident's room change occurred on December 9, 2025 and that written notification of the room change was provided to the resident's responsible party. Continued review of the clinical record also did not show evidence of any written notification to the resident and/or responsible party prior to the move, including an explanation as to why the move was needed. During a discussion with the Director of Nursing (DON) September 5, 2025 at 12:27 p.m. it was discussed that there was no evidence that the resident/responsible party was received written notice, including the reason for the change, prior the resident's room /roommate in the facility was changed. 28 Pa. Code 201.29(c) Resident Rights 28 Pa. Code 201.29(c.3)(1) Resident Rights 28 Pa. Code 211.12(c) Nursing services 28 Pa. Code 211.12(d)(5) Nursing services		

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. Based on review of facility policy, review of clinical records, observations, and staff interviews it was determined that the facility failed to provide personal privacy during care for two of 17 residents reviewed (Resident R3, and R46). Findings Include: Observation of the first-floor unit conducted September 2, 2025, at 10:56AM revealed that Nurse Aide, Employee E4, was providing care for Resident R3. Further observation revealed that Resident R3's roommate was in Bed-B, next to the window. Further, the privacy curtain for Resident R3 was drawn only partially at foot of the bed, exposing Resident R3 to his/her roommate. Interview with the Director of Nursing (DON), Employee E2, conducted at the time of the observation confirmed that Nurse Aide, Employee E4, did not fully draw the curtain to provide Resident R3 with full privacy during care. Further observation of the first-floor unit conducted September 2, 2025, at 12:24PM revealed that Nurse Aide, Employee E4, was providing care for Resident R46. Further observation revealed that Resident R46's roommate was in Bed-B next to the window. Further, the privacy curtain for Resident R46 was drawn only partially at foot of the bed, exposing Resident R46 to his/her roommate. Interview with the DON, Employee E2, conducted at the time of the observation confirmed that Nurse Aide, Employee E4, did not fully draw the curtain to provide Resident R46 with full privacy during care. 28 Pa. Code 201.29 (a) Resident rights. 28 Pa. Code 211.12 (d)(1) Nursing services.		

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. Based on staff interviews, and review of clinical records, it was determined that that facility failed to ensure that prompt efforts were made to resolve a resident's grievance regarding a room change request for 1 out of 17 residents reviewed (Resident R51). Findings include: Review of Resident R51's August 2025 physician orders revealed the diagnoses of schizoaffective disorder (a mental health condition that is marked by a mix of schizophrenia symptoms, such as see things and hearing voices and believing things that are not real or true, anxiety (intense, excessive and persistent worry and fear about everyday situations); adjustment disorder (a mental health condition characterized by an excessive emotional or behavioral response to a significant life stressor, leading to distress and functional impairment); hypertension (high blood pressure); muscle weakness, and hyperlipidemia (high cholesterol). Review of the facility's undated policy, Grievances/Complaints, Filing, indicated that all grievances, complaints or recommendations stemming from resident or family groups concerning issues of resident care in the facility will be considered. The policy also indicated that actions on such issues will be responded to in writing, including a rationale for the response. Continued review of the policy indicated that grievances and/or complaints may be submitted orally or in writing, and may be filed anonymously. Review of a nursing note written by the Director of Nursing (DON) dated April 18, 2025 at 2: 33 p.m. indicated that the DON received a call from the resident concerning another resident on the 2nd floor nursing unit where the resident resided, and as result, the resident contacted the DON requesting to move to the 1st floor. Call received from [Name of Resident]. She has non-emergent concern regarding another resident on the unit and is requesting move to the 1st floor. [Name of Resident] continues to be a risk to a resident's safety on the 1st floor. Notified the primary nurse of [Name of Resident] concern and monitoring for the concern is initiated. Attempt to notify [Resident's Guardian] is unsuccessful. Message is left with receptionist for return call on Monday, 4/21/25. Continued review of the clinical record and facility documentation did not show evidence that the facility made prompt efforts to resolve the resident's grievance regarding a request for a room change. During an interview with the Director of Nursing on September 5, 2025 at 12:50 p.m. no documentation could be produced by the DON to show evidence that prompt efforts were made by the facility to address the resident's grievance requesting a room change. 28 Pa. Code 201.18 (b)(1)(3) Management 28 Pa. Code 201.18 (d.1)(4) Management 28 Pa. Code 201.29 (a) Resident Rights		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and staff interview, it was determined that the facility failed to revise a care plan related to aggressive behaviors for one of 17 residents reviewed. (Resident R51) Findings include: Review of the August 2025 physician orders for Resident R51 revealed the diagnoses of schizoaffective disorder (a mental health condition that is marked by a mix of schizophrenia symptoms, such as see things and hearing voices and believing things that are not real or true, and mood disorder symptoms; anxiety (intense, excessive and persistent worry and fear about everyday situations); adjustment disorder (a mental health condition characterized by an excessive emotional or behavioral response to a significant life stressor, leading to distress and functional impairment); hypertension (high blood pressure); muscle weakness, and hyperlipidemia (high cholesterol). Review of the resident's quarterly Minimum Data Set Assessment (MDS- a periodic assessment of a resident's needs) dated May 2, 2025 indicated that the resident cognitive intact. Review of the September 2025 physician orders for Resident R23 revealed the diagnoses of psychosis; bipolar; schizophrenia; dementia; unspecific pain; cataracts; cognitive communication deficit and anxiety. CReview of the resident's person-centered plan of care included a plan of care dated July 7, 2022 for the behavior of wandering the halls and going into other resident rooms. Interventions included re-directing the resident as needed for behavioral episodes. Review of Resident R23's quarterly MDS dated [DATE] indicated that the resident was cognitively impaired. Review of Resident R23's nursing note dated May 22, 2025 at 2:53 a.m. revealed that resident was very aggressive and had to be redirected by staff. The note also documented that the resident was seen going to room [XXX] multiple times and that Resident R51 got upset and threw a trashcan at Resident R23, directing the resident to get out of her room. Resident with very aggressive behavior hard to redirect by staff. Resident going to room [ROOM NUMBER]A multiple times. Resident in room [ROOM NUMBER]A was upset throw the trash can to (him/her) screaming Get out of my room and c/o (complaint) about [Name of Resident] going to her room. Resident also noted going to the elevator. Resident with wanderguard in placed. Will give report to incoming Nurse. Resident refused to go to his room. Resident is sitting at the nurses station for close monitoring. Will continue to monitor. Snack was given to resident. Review of a nursing note dated May 22, 2025 at 2:00 p.m. documented that Employee E13 (licensed nurse) observed Resident R51 hitting Resident R23 with a trash can. Resident R23 reported to the nurse that he did not know why Resident R51 hit him with the trash can. this nurse was exiting room [XXX] when i observed the other resident hitting this resident with a trash can at the back of (his/her) head. this resident stated (he/she) is unsure of why other resident hit (him/her) with the trash can. This nurse removed resident from hallway into the lounge area. nurse did a skin check to head, no skin issues present. pain assessed as well, no pain. md (physician) . notified upon arrival facility. nurse tried to contact the contacts on file for resident, no answer. nursing sup (supervisor)/adon (assistant director of nursing) notified. Review of Resident R51's care plan revealed that a care plan was developed on March 20, 2024 related to the resident exhibiting an increase of agitation. A focus area was added on May 22, 2025 I threw a garbage can at a resident when (he/she) entered my room. The interventions included encourage medication compliance and notify the police of physical aggression towards others. Continued review of the resident's care plan revealed that on June 10, 2025 a care pan was developed with a focus area I am known not to use the STOP sign at my door. The only intervention listed was magnetic stop sign is placed across my door. Interview conducted on September 5, 2205 at 12:27 p.m. with the Director of Nursing confirmed that Resident R51 refused to keep stop sign in front of her door and kept removing it. There was no documented evidence that the resident's care plan was revised to include interventions to assist Resident R51 in decreasing aggressive behaviors towards residents who may wander into (his/her) (continued on next page)		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview and review of facility policy, it was determined that the facility failed to ensure that proper feeding tube placement was established prior to administering medication through a feeding tube for one of two residents observed (Resident RF27). Findings include: Review of facility Policy on Administering medications through an Enteral Tube revised in March 2015, revealed that under section Purpose: The purpose of this procedure is to provide guidelines for the safe administration of medications through an enteral tube. To assess for tolerance of enteral feeding. Under section Equipment and supplies: 12: Stethoscope. Under section Steps in the Procedure: 18. Conform placement of feeding tube. #20. Check gastric residual volume to assess tolerance of enteral feeding. #21 when correct tube placement and acceptable gastric residual volume have been verified, flush tubing with 15-30 ml warm sterile water (or prescribed amount). Review of Resident R27's clinical record revealed that Resident R27 was admitted to the facility on [DATE], with diagnoses of but not limited to: Chronic Obstructive Pulmonary Disease. Review of Resident R27's MAR (medication administration Record) for September 2025 revealed the following medications: Fludrocortisone Acetate Oral Tablet 0.1 MG (Fludrocortisone Acetate) Give 1 tablet via PEG-Tube (Percutaneous Endoscopic Gastrostomy- a tube that is connected to the stomach used to provide feeding and administering medications) one time a day, Multivitamin Oral Liquid (Multiple Vitamins w/ Minerals) Give 5 ml via PEG-Tube one time a day, Sertraline HCl Oral Tablet 25 MG, Give 25 mg via PEG-Tube one time a day, Apixaban Oral Tablet 5 MG Give 5 mg via PEG-Tube two times a day, Docusate Sodium Oral Liquid 50 MG/5ML, Give 10 ml via PEG-Tube two times a day. Review of Resident R27's MDS (minimum data set- a federally required resident assessment completed at a specific interval) dated June 24, 2025, section K0520. Nutritional Approaches, B. Feeding tube (e.g., nasogastric or abdominal (PEG) revealed that resident was on tube feeding. Medication administration observation on Resident R27 conducted on September 3, 2025, at 10:01 AM with Licensed nurse, Employee E5 revealed that Employee E5 crushed all of Resident R27's medications and mixed it with water. Further, Employee E 5 then proceeded to administer Resident R27's medication via tube feeding without checking for placement. Interview with Licensed nurse, Employee E5 conducted at the time of the observation confirmed that she did not check Resident R27's PEG) tube for placement. Interview with DON (Director of Nursing) conducted on September 3, 2025, at 12:05PM revealed that placement of feeding tubes must be checked and confirmed prior to administering medications. 28 Pa. Code 204.14(a) Responsibility of licensee 28 Pa. Code 201.18 (e)(1) Management 28 Pa. Code 211.12 (d) (1) Nursing services		

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NAME OF PROVIDER OR SUPPLIER Rosemont Center		STREET ADDRESS, CITY, STATE, ZIP CODE 35 Rosemont Avenue Rosemont, PA 19010	
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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, review of clinical records, observations, and staff and resident interviews it was determined that the failed to provide treatment/services to maintain or improve range of motion/mobility for one of four residents reviewed for limited range of motion (Resident R12). Findings Include: Review of facility policy Restorative Nursing Services revised July 2017 revealed residents will receive restorative nursing care as needed to promote optimal safety and independence. Review of Resident R12's quarterly Minimum Data Set (MDS - federally mandated resident assessment and care screening) dated August 5, 2025, revealed the resident was cognitively intact and had diagnoses of hemiplegia (affecting left non-dominant side), muscle weakness, and need for assistance with personal care. Further review of Resident R12's MDS dated [DATE], revealed the resident had impairment of functional limitation in range of motion on one side to the upper and lower extremities. Review of Resident R12's occupational therapy Discharge summary dated [DATE], by Occupational Therapist, Employee E11, revealed a splint was recommended to maintain level of performance and in order to prevent decline. Review of Resident R12's comprehensive care plan dated November 14, 2024, revealed Resident R1 should wear left resting hand splint after morning care and taken off prior to bedtime care, as tolerated. The goal was to maintain the left hand and arm range of motion and prevent contractures. Observation on September 3, 2025, at 1:29 p.m. revealed Resident R12 was not wearing the left-hand splint. Resident R12 reported staff does not apply the splint daily. Interview on September 3, 2025, at 1:38 p.m. with Licensed Nurse, Employee E5, reported he/she was unaware of a splint for Resident R12. Interview on September 3, 2025, at 1:39 p.m. with Nurse Aide, Employee E9, revealed he/she was unaware of a splint for Resident R12. Interview on September 4, 2025, at 9:15 a.m. with the Director of Rehab, Employee E10, confirmed Resident R12 should have the splint applied every morning and removed every night. Observations on September 4, 2025, at 9:45 a.m. revealed Resident R12 was again not wearing the left-hand splint. Resident R12 reported someone from therapy attempted to apply the splint but could not get it on. Interview on September 4, 2025, at 9:48 a.m. with the Director of Rehab, Employee E10, revealed he/she tried to apply Resident R12's left hand splint but had trouble getting it on. Director of Rehab, Employee E10, reported that occupational therapy is going to reassess the resident. Interview on September 4, 2025, at 1:40 p.m. with Occupational Therapist, Employee E11, confirmed he/she recommended a left-hand splint for Resident R12 in July 2025. Continued interview on September 4, 2025, at 1:40 p.m. Occupational therapist, Employee E11, reported that upon reassessment [on September 4, 2025] Resident R12 was no longer able to tolerate the hand splint due to worsening contracture. Occupational therapist, Employee E11, explained that the splint required Resident R12 to be able to lay his/her fingers flat, which Resident R12 was no longer able to do. 28 Pa. Code 211.10(d) Resident care policies 28 Pa. Code 211.12(d)(3) Nursing services		

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, review of facility documentation, review of personnel files, review of clinical records, observations, and staff interviews it was determined that the facility failed to assure that nursing staff possess the competencies, and skill sets necessary to provide nursing and related services to meet the residents' needs for two of five nursing staff reviewed (Employee E5 and E9). Findings Include: Review of facility policy Restorative Nursing Services revised July 2017 revealed residents will receive restorative nursing care as needed to promote optimal safety and independence. Review of facility's job description for nurse aides revealed that nurse aide staff are responsible for reviewing care plans and daily assignments and perform nursing care as outlined. Review of facility's job description for licensed practical nurse (LPN) revealed that LPN staff are responsible for rendering professional nursing care to residents, follow facility policies and procedures to implement treatment orders and to maintain residents' medical records. Review of Resident R12's quarterly Minimum Data Set (MDS - federally mandated resident assessment and care screening) dated August 5, 2025, revealed the resident was cognitively intact and had diagnoses of hemiplegia (affecting left non-dominant side), muscle weakness, and need for assistance with personal care. Further review of Resident R12's MDS dated [DATE], revealed the resident had impairment of functional limitation in range of motion on one side to the upper and lower extremities. Review of Resident R12's occupational therapy Discharge summary dated [DATE], by Occupational Therapist, Employee E11, revealed a splint was recommended to maintain level of performance and in order to prevent decline. Review of Resident R12's comprehensive care plan dated November 14, 2024, revealed Resident R1 should wear left resting hand splint after morning care and taken off prior to bedtime care, as tolerated. The goal was to maintain the left hand and arm range of motion and prevent contractures. Review of Resident R12's nursing kardex (a documentation system that enables nurses to write, organize, and easily reference key patient information that shapes their nursing care plan) task dated August 3, 2025, revealed the assigned nurse aide should apply the left resident hand splint after morning care and taken off prior to nighttime care. Review of facility documentation revealed Nurse aide, Employee E9, was assigned to provide care for Resident R12 on September 3, 2025, during the 7:00 a.m. to 3:00 p.m. shift. Observation on September 3, 2025, at 1:29 p.m. revealed Resident R12 was not wearing the left-hand splint. Resident R12 reported staff does not apply the splint daily. Interview on September 3, 2025, at 1:38 p.m. with Licensed Nurse, Employee E5, reported he/she was unaware of a splint for Resident R12. Interview on September 3, 2025, at 1:39 p.m. with Nurse Aide, Employee E9, revealed he/she was unaware of a splint for Resident R12. When asked about the splint, Nurse aide Employee E9, stated I don't know I'm agency staff. Review of Employees E5 and E9's personnel files revealed no evidence that the employees received any skills competency evaluations to ensure competency of hands-on skills and techniques necessary to care for residents' needs. 28 Pa. Code 201.19(7) Personnel policies and procedures 28 Pa. Code 201.20(b) Staff development		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on review of facility policy, observations, and staff interview it was determined that the facility failed to store and prepare food in accordance with standards of food service safety (Main Kitchen). Findings Include:Review of undated facility policy Food Storage revealed leftover food is stored in covered containers or wrapped carefully and securely.Observations during an initial tour of the main kitchen on September 2, 2025, at 9:00 a.m. with Food Service Director, Employee E6, revealed the following:Observations of the walk-in refrigerator revealed deli meats in open plastic bags, not sealed. Further observations revealed opened containers of chicken and beef broth base, with no open date.Observations in the walk-in freezer revealed a box of cauliflower open to air, not sealed. 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 review of facility policy, review of clinical records, observations, and staff interviews it was determined that the facility failed to implement an effective infection control program related to medication administration and the use of personal protective equipment (PPE) in enhanced barrier precautions 4 of 17 residents reviewed (Resident R27, R47, R14, R59). Findings Include: Review of facility policy on Enhanced Barrier Precaution (EBP) dated April 1, 2024, revealed that it is the policy of the facility to follow state and federal guidelines to minimize the spread of Multidrug Resistant Organism (MDRO's) by implementing effective personal protective equipment (PPE) usage. The policy is intended to provide guidance for PPE use as well as room restriction for preventing transmission of MDRO's. Under section Key Points #2. EBP is indicated for residents with the following: wounds or indwelling medical devices, regardless of MDRO colonization status; infections or colonization with an MDRO when contact precaution do not otherwise apply. Observation of the first-floor unit conducted September 2, 2025, at 10:56AM revealed that an Enhanced barrier Precaution Signage was posted outside Resident R3's door to his bedroom. Observation of Resident R3 revealed that Nurse's Aide Employee E4 was providing care to Resident R3. Further observation revealed that Employee E4 was wearing gloves but not wearing a gown while providing care to Resident R3. Interview with DON (Director of Nursing) Employee E2 conducted at the time of the observation confirmed that Resident R3 was on EBP. Further, DON Employee E2 revealed that staff were required to wear gown and gloves when caring for Resident R3. Further DON Employee E2 confirmed that Nurse's Aide Employee E4 was not wearing gown while providing ADL care to Resident R3. Observation of the first-floor unit conducted September 2, 2025, at 12:24PM revealed that an Enhanced barrier Precaution Signage was posted outside Resident R46's door to her bedroom. Further observation revealed that nurse aide, Employee E4, was wearing gloves but was not wearing a gown. Interview with the DON, Employee E2, conducted at the time of the observation confirmed that Resident R46 was on enhanced barrier precautions and that gown and gloves was required when providing care. Director of Nursing, Employee E2, confirmed that nurse aide, Employee E4, was not wearing gown. Medication administration observation was conducted on September 3, 2025, at 10:01 AM with licensed nurse, Employee E5. Medication observation was observed for Residents R27, R47, R14, and R59. Licensed nurse, Employee E5, administered eye drops for Resident R27 without sanitizing hands before putting on and after taking off his/her gloves. Further, licensed nurse, did not sanitize hands between medication administrations for the identified residents. Review of Resident R27's comprehensive care plan dated August 6, 2024, revealed the resident was on enhanced barrier precautions related to indwelling medical devices (suprapubic catheter - medical device used to drain urine from the bladder through a small incision in the abdomen). Interventions dated August 6, 2024, instructed staff to wear gloves and gowns for high contact resident care. Observations on September 4, 2025, at 1:20 p.m. revealed nurse aide, Employee E8, was emptying Resident R27's catheter bag at bedside and was not wearing a gown. Medication administration observation on Resident R27 conducted on September 3, 2025, at 10:01 AM with Employee E5 revealed that Employee E5 did not sanitize her hands before and after preparing Resident R27's medications. Further observation revealed that Employee E5 did not sanitize her hands before and after administering Resident R27's medications via feeding tube. Further observation revealed that before administering artificial tears to Resident R27's left eye. Further, Employee E5 did not sanitize her hands after administering eye drops on resident R27's left eye, did not sanitize her hands before administering artificial tears to Resident R27's right eye and Employee E5 did not sanitize her hand after administering artificial tears to resident R26's right eye. Interview with Employee E5 conducted at the time of the observation confirmed that she did not sanitize or wash her hands during the medication administration for Resident R27. 28 Pa Code 211.12 (d)(1)(5) Nursing services 28 Pa. Code 211.12 (d)(1) 28 Pa. Code 211.12 (d)(5)		