STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395217	A. Building B. Wing	06/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Richboro Rehabilitation & Nursing Center	253 Twining Ford Road Richboro, PA 18954

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 facility policy review, observation, and staff interview, it was determined that the facility failed to properly store food and maintain sanitary conditions in the dietary department. Findings include:Review of the facility's policy entitled, Date Marking for Food Safety, dated February 17, 2026, revealed that staff were to check the refrigerator routinely for food items that were expiring and discard perishable foods that were held at 41 degrees Fahrenheit or lower after seven days.Observations during the tour of the dietary department on June 23, 2026, at 11:00 a.m., revealed the following:In the dry storeroom, there was an air conditioning unit in a window that was on and blowing air out of it. Below it, along the length of the window shelf, there was a layer of dirt, debris, and dead insects. The air conditioning unit was adjacent to the bulk food containers with lids. On the floor next to the air conditioning unit, there was a crate of 12 boxes of baking soda directly touching the floor. Below the crate, there were two discolored sugar packets and a packet of ketchup and a black substance on the floor. There was a bag of biscuit mix removed from the original packaging that was not dated. In the utensil drawer, there was a plastic spatula that was chipped on the scrapper part.In the walk-in cooler, there was a pan of egg salad dated June 13, 2026, and a pan of sliced ham dated June 11, 2026.In the freezer, on both sides of the entrance, there were two large areas of ice accumulation. There was an unsealed bag of chicken that was open to air.There was a window fan blowing air into the kitchen that was across from the meal service tray line. The fan shield had a layer of dust along the length of it with little peaks of dust. The lunch meal service was occurring at this time.In the dish machine room, on top of the dish machine there was an opened bottle of caramel sauce that had leaked and left food residue on top of the machine. There were two ceiling tiles that were stained.In an interview on June 23, 2026, at 11:30 a.m., the Dietary Manager confirmed the previously mentioned item should have been dated and the expired items should have been removed and were not.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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **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 develop a comprehensive care plan that addressed individual resident needs as identified in the comprehensive assessment for two of 19 sampled residents. (Residents 45 and 77)Findings include: Clinical record review revealed that Resident 45 had a diagnosis of malnutrition and had full upper and lower dentures. Review of the Minimum Data Set (MDS) assessment dated [DATE], identified that the resident had no natural teeth and required assistance with oral hygiene. According to the Care Area Assessment (CAA) summary dated May 24, 2026, the facility identified that dental care was a problem for the resident and should have been included in the comprehensive care plan. Review of the care plan revealed that the facility did not develop interventions to address the care area of dental care. Clinical record review revealed that Resident 77 had a diagnosis of cataracts in both eyes, right eye blindness, and left sided hemiplegia (paralysis affecting one side of the body). Review of the MDS assessment dated [DATE], identified that the resident required assistance with toileting, hygiene, and showering and had a fall since the last assessment. According to the CAA summary dated June 15, 2026, the facility identified that visual function was a problem for the resident and should have been included in the comprehensive care plan. Review of the care plan revealed that the facility did not develop interventions to address the care area of visual function. In an interview conducted on June 26, 2026, at 12:10 p.m., the Director of Nursing confirmed that there was no care plan developed with interventions to address Resident 45's dental care and Resident 77's visual function. 28 Pa. Code 211.12(d)(5) Nursing services.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, observation, and staff interview, it was determined that the facility failed to provide care and services to maintain activities of daily living (personal hygiene) for one of 18 sampled resident. (Resident 68) Findings include: Clinical record review revealed that Resident 68 had diagnoses that included a history of stroke, dementia, and was legally blind. A Minimum Data Set assessment dated [DATE], revealed that Resident 68 had moderate cognitive impairment and was dependent on staff for all activities of daily living (ADL's) including personal hygiene. Review of the ongoing care plan revealed that staff were to assist the resident with personal hygiene and self-care. On June 23, 2026, at 10:10 a.m., and June 24, 2026, at 12:30 p.m., the resident was observed in her bed. Her nails on both hands were long and dirty. Facility documentation revealed that Resident 68 was last bathed by staff on June 24, 2026, at 8:31 p.m. On June 25, 2026, at 10:02 a.m., the resident was observed in her bed. Her nails remained long with dirt beneath them. There were no documented refusals of care. In an interview on June 26, 2026, at 11:10 a.m., the Director of Nursing confirmed that nail care was to be done on shower days. 28 Pa. Code 211.12(d)(1)(5) Nursing services.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on clinical record review and staff interview, it was determined that the facility failed to ensure physicians' orders were implemented for one of 18 sampled residents. (Resident 9) Findings include: Clinical record review revealed that Resident 9 had diagnoses that included hypertension (high blood pressure). On April 9, 2026, the physician ordered staff to administer blood pressure medications, metoprolol and losartan, each once per day. Staff were not to administer either medication if the resident's systolic blood pressure (SBP, the first measurement of blood pressure when the heart beats and the pressure is at its highest) was less than 120 millimeters of mercury (mm Hg). Review of Resident 9's June 2026 Medication Administration Record revealed that staff administered the metoprolol 15 times and the losartan two times when the SBP was below 120 mm Hg. In an interview on June 26, 2026, at 11:10 a.m., the Director of Nursing confirmed that the physician's orders were not followed for Resident 9. CFR 483.25 Quality of CarePreviously cited 5/29/25 28 Pa. Code 211.12(d)(1)(5) Nursing services.

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F 0628 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on clinical record review and staff interview, it was determined the facility failed to provide copies of the written discharge notices to a representative of the Office of the Long-Term Care Ombudsman for two of two residents who were discharged from the facility. (Residents 83 and 87)Findings include: Clinical record review revealed that Resident 83 was discharged from the facility on April 8, 2026. There was no documented evidence that the facility sent copies of the written discharge notice to a representative of the Office of the State Long-Term Care Ombudsman.Clinical record review revealed that Resident 87 was discharged from the facility on February 24, 2026. There was no documented evidence that the facility sent copies of the written discharge notice to a representative of the Office of the State Long-Term Care Ombudsman.In an interview on June 26, 2026, at 11:33 a.m., the Social Services Director confirmed that the written copies of the discharge notices were not sent to the Office of the State Long-Term Care Ombudsman.28 Pa. Code 201.14(a) Responsibility of licensee.