

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

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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395277	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/23/2026
NAME OF PROVIDER OR SUPPLIER Harborview Rehabilitation Care Center at Doylestown		STREET ADDRESS, CITY, STATE, ZIP CODE 432 Maple Avenue Doylestown, PA 18901	
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 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure that a working call system is available in each resident's bathroom and bathing area. Based on staff interview, and review of facility documentation the facility failed to provide a working call bell system for 96 residents on all three nursing units. (First, Second, Third floor nursing units) Review of facility documentation dated May 13, 2025, revealed that the electric call bell system was not functioning properly for several resident rooms. In an interview on July 27, 2026, at 11:15 a.m., the Administrator stated that the electric call bell system was still not functioning on the first, second and third floor nursing units. The Administrator further stated that there was a total of 96 out of 116 call bells that were not functioning in resident rooms. The facility failed to ensure that the electric call bell system in which residents were able to call for staff through a communication system which relayed the call directly to a staff member or to a centralized work area from each resident's bedside if they were in need of assistance was operational and fixed in a timely manner. 28 Pa. Code 201.18(b)(3) Management. 28 Pa. Code 211.12 (d)(5) Nursing services.		

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 395277	Facility ID: 395277
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