

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  395350	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  06/27/2025
NAME OF PROVIDER OR SUPPLIER  Locust Grove Retirement Village		STREET ADDRESS, CITY, STATE, ZIP CODE  69 Cottage Road Mifflin, PA 17058	

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)
<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>Based on clinical record review and staff interview, it was determined that the facility failed to implement a comprehensive person-centered care plan regarding behaviors for one out of three residents reviewed for behaviors (Resident 54).</p> <p>Findings Include:</p> <p>Review of Resident 54's clinical record revealed that the facility admitted her on March 14, 2023. A Minimum Data Set Assessment (MDS, an assessment completed at specific intervals to determine care needs) dated March 20, 2023, indicated that the facility assessed her as having behaviors, such as refusal of care and agitation. The facility implemented a plan of care to address Resident 54's behaviors on March 17, 2023. There was no documented evidence in Resident 54's plan of care regarding interventions for staff to utilize if Resident 54 exhibits those behaviors during care.</p> <p>Review of Resident 54's plan of care for behaviors dated June 1, 2023, revealed that the facility added additional exhibited behaviors such as slapping and being combative with staff. There was no documented evidence in Resident 54's plan of care regarding interventions for staff to utilize if Resident 54 exhibits those behaviors during care.</p> <p>Nursing documentation on January 28, 2025, at 12:08 PM revealed that Resident 54 bit a staff member during care, leaving bite marks.</p> <p>Nursing documentation dated March 13, 2025, at 9:21 PM revealed that Resident 54 was combative with staff during a shower.</p> <p>Nursing documentation dated April 1, 2025, at 12:44 AM revealed that it took four staff members to provide incontinence care to Resident 54. Resident 54 was kicking, spitting, and biting at staff.</p> <p>There was no documented evidence in Resident 54's plan of care to indicate that the facility implemented individualized interventions regarding her behaviors, since its inception upon admission.</p> <p>The findings for Resident 54 were reviewed during an interview with the Administrator and Director of Nursing on June 25, 2025, at 2:00 PM.</p> <p>28 Pa. Code 211.10 (a)(c)(d) Resident care policies</p> <p>28 Pa. Code 211.12(d)(1)(3)(5) Nursing services</p>

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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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>Based on clinical record review and staff interview, it was determined that the facility failed to provide the highest practicable care regarding physician ordered medication parameters for two of 17 residents reviewed (Residents 32 and 51) and failed to provide comprehensive skin assessments that are consistent with professional standards of practice, to promptly identify skin changes and to promote healing for one of three residents reviewed for skin condition concerns (Resident 1).</p> <p>Findings include:</p> <p>Clinical record review for Resident 51 revealed a diagnosis list that included essential hypertension (high blood pressure).</p> <p>Review of Resident 51's current care plan revealed the resident has hypertension and an intervention included to give anti-hypertensive medications as ordered and monitor for side effects such as orthostatic hypotension (a sudden drop in blood pressure when a person stands up) and increased heart rate, and effectiveness.</p> <p>Resident 51's care plan also noted the resident has a potential for an altered cardiovascular status related to the medical history.</p> <p>A review of the current physician orders for Resident 51 revealed an order dated August 13, 2024, for Metoprolol Succinate ER Extended Release (a medication that is used to treat high blood pressure and/or heart rate) 25 milligrams (mg) give one tablet by mouth one time a day for essential hypertension. Hold for a systolic blood pressure (SBP, the top number of a blood pressure reading where the heart contracts) less than 100 and/or a heartrate less than 60.</p> <p>A review of the Medication Administration Record (MAR) for Resident 51 revealed that the Metoprolol was marked as administered outside of the physician specified parameters for the following:</p> <p>April 4, 2025: the resident's blood pressure was documented as 97/55.</p> <p>April 12, 2025: the blood pressure was documented as 97/61.</p> <p>April 14, 2025: the pulse was documented as 59.</p> <p>April 27, 2025: the blood pressure was documented as 93/51.</p> <p>May 7, 2025: the blood pressure was documented as 88/59.</p> <p>May 30, 2025: the blood pressure was documented as 82/47.</p> <p>June 10, 2025: the blood pressure was documented as 98/60.</p> <p>The above information for Resident 51 was reviewed in a meeting with the Nursing Home Administrator (NHA) and Director of Nursing (DON) on June 26, 2025, at 11:00 AM.</p> <p>(continued on next page)</p>

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The NHA confirmed on June 27, 2025, at 9:35 AM that there was no documented evidence why the medication was administered outside of the physician ordered parameters.</p> <p>Clinical record review for Resident 32 revealed the following physician orders:</p> <p>On April 17, 2024, for staff to notify the physician if the blood sugar was less than 60 mg/dL (milligrams/deciliter) or greater than 400 mg/dL.</p> <p>On April 27, 2024, for staff to monitor their blood sugar before meals and at bedtime for diabetes (high blood sugar).</p> <p>Review of Resident 32's clinical documentation revealed the following:</p> <p>On May 3, 2025, at 8:00 PM 415 mg/dL.</p> <p>On May 6, 2025, at 5:00 PM 507 mg/dL.</p> <p>On May 6, 2025, at 8:00 PM 444 mg/dL.</p> <p>On May 8, 2025, at 12:30 PM 601 mg/dL.</p> <p>On May 8, 2025, at 5:00 PM 601 mg/dL.</p> <p>On May 8, 2025, at 5:00 PM staff documented NA (not applicable).</p> <p>On May 8, 2025, at 8:00 PM staff documented NA.</p> <p>On May 12, 2025, at 5:00 PM staff documented NA.</p> <p>On May 14, 2025, at 5:00 PM staff documented NA.</p> <p>On May 14, 2025, at 9:00 PM staff documented NA.</p> <p>On May 15, 2025, at 12:30 PM 539 mg/dL.</p> <p>On May 17, 2025, at 12:30 PM 586 mg/dL.</p> <p>On May 17, 2025, at 5:00 PM 541 mg/dL.</p> <p>On May 20, 2025, at 12:30 PM 493 mg/dL.</p> <p>On May 22, 2025, at 5:00 PM staff documented NA.</p> <p>On May 22, 2025, at 9:00 PM staff documented NA.</p> <p>On May 24, 2025, at 12:30 PM 439 mg/dL.</p> <p>On May 24, 2025, at 5:00 PM 400 mg/dL.</p> <p>(continued on next page)</p>

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On May 25, 2025, at 7:30 AM 405 mg/dL.</p> <p>On May 26, 2025, at 5:00 PM staff documented NA.</p> <p>On May 26, 2025, at 9:00 PM staff documented NA.</p> <p>On May 27, 2025, at 12:30 PM 485 mg/dL.</p> <p>On May 29, 2025, at 12:30 PM 500 mg/dL.</p> <p>On May 31, 2025, at 12:30 PM 537 mg/dL.</p> <p>On May 31, 2025, at 5:00 PM 592 mg/dL.</p> <p>On May 31, 2025, at 8:00 PM 472 mg/dL.</p> <p>On June 1, 2025, at 11:30 AM 447 mg/dL.</p> <p>On June 3, 2025, at 12:30 PM 488 mg/dL.</p> <p>On June 5, 2025, at 5:00 AM 420 mg/dL.</p> <p>On June 5, 2025, at 12:30 PM 508 mg/dL.</p> <p>On June 7, 2025, at 12:30 PM 479 mg/dL.</p> <p>On June 12, 2025, at 12:30 PM 540 mg/dL.</p> <p>On June 14, 2025, at 12:30 PM 580 mg/dL.</p> <p>On June 14, 2025, at 5:00 PM 473 mg/dL.</p> <p>On June 15, 2025, at 11:30 AM 413 mg/dL.</p> <p>On June 17, 2025, at 12:30 PM 412 mg/dL.</p> <p>On June 19, 2025, at 12:30 PM 434 mg/dL.</p> <p>On June 19, 2025, at 5:00 PM 426 mg/dL.</p> <p>On June 20, 2025, 7:30 AM 559 mg/dL.</p> <p>On June 21, 2025, at 5:00 PM 406 mg/dL.</p> <p>On June 23, 2025, at 7:30 AM 525 mg/dL.</p> <p>On June 24, 2025, at 12:30 PM 478 mg/dL.</p> <p>(continued on next page)</p>

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The above information was reviewed during an interview on June 26, 2025, at 10:45 AM with the Nursing Home Administrator and Director of Nursing. There was no evidence that the facility notified the physician of the elevated blood sugars.</p> <p>Review of Resident 1's clinical record revealed a current physician's order initiated May 10, 2025, that indicated nursing staff were to use Medihoney (a wound gel that promotes healing and removes necrotic tissue) and border gauze to Resident 1's right glute (buttock) open area every day.</p> <p>There was no documented evidence to indicate that the facility completed a skin assessment to determine the status or measurement of Resident 1's open buttock area on May 10, 2025 or after.</p> <p>There was no documented evidence on Resident 1's Medication Administration Record (MAR, a form used to document the administration of medications) or Treatment Administration Record (TAR, a form used to document the administration of treatments) to indicate that the treatment ordered to her right buttock on May 10, 2025, was completed as ordered.</p> <p>The above findings for Resident 1 were reviewed during an interview with the Administrator of June 26, 2025, at 2:00 PM.</p> <p>483.25 Quality of Care</p> <p>Previously Cited 5/3/2024</p> <p>28 Pa. Code 211.12(d)(1)(3)(5) Nursing services</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>Based on clinical record review, observations, and staff interview, it was determined that the facility failed to implement preventative measures to prevent pressure ulcers for one of three residents reviewed for pressure ulcer concerns (Resident 67).</p> <p>Findings include:</p> <p>Clinical record review revealed the facility admitted Resident 67 on November 19, 2024. Review of Resident 67's admission assessment noted that she had no open areas on her feet.</p> <p>A nursing progress note date January 4, 2025, at 6:26 AM revealed that Resident 67's left heel had bleeding and bruising noted. New orders were received for skin prep (applied to the skin to create a film to protect the skin) to bilateral heels, and to elevate heels while in bed.</p> <p>Further clinical record review revealed a wound clinic note dated February 3, 2025, that indicated Resident 67 had a new left heel deep tissue injury (DTI, skin injury that occurs beneath the surface of the skin due to sustained pressure) with current measurements of 5.5 cm (centimeter) x 6.5 cm, 100% eschar. The note indicated to cleanse with Dakin's (an antimicrobial cleanser) 1.25%, then apply Dakin's-soaked fluffed gauze to the wound, cover with an ABD (abdominal gauze pads used to absorb discharges from draining wounds) pad, and change twice a day and as needed.</p> <p>Clinical record review of Resident 67's Braden scale (a scale used to predict pressure sore risk) dated December 3, 2024, revealed Resident 67 was assessed at a Braden score of 19 indicating that she was not at risk for pressure ulcer development. Further review revealed a Braden scale dated December 10, 2024, that indicated Resident 67 was assessed at a Braden score of 17, indicating she was at risk for pressure ulcer development.</p> <p>Review of Resident 67's care plan revealed a care plan entitled at risk for skin break down and pressure ulcer development, initiated on November 20, 2024, and last revised on November 24, 2024, revealed current interventions of a preventative mattress and turn and reposition as needed. Interview with the Nursing Home Administrator on June 27, 2025, at 10:10 AM revealed that the preventative mattress on Resident 67's bed was not a specialty mattress.</p> <p>Further review of Resident 67's care plan revealed that there were no new preventative pressure interventions initiated after her Braden scale assessment on December 10, 2024, that indicated her at-risk score decreased and she was at risk for pressure ulcer development.</p> <p>The facility failed to initiate preventative pressure ulcer interventions for Resident 67, after her Braden score assessment on December 10, 2024, determined she was as risk for pressure ulcer development, and she developed a DTI to her left heel on January 4, 2025.</p> <p>The Nursing Home Administrator and Director of Nursing were made aware of the above noted findings related to Resident 67's pressure ulcer on June 26, 2025, at 2:30 PM.</p> <p>83.25(b)(1)(i)(ii) Treatment/svcs to Prevent/heal Pressure Ulcer</p> <p>Previously cited deficiency 5/3/24</p> <p>(continued on next page)</p>		

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F 0686  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	28 Pa. Code 211.10(a)(d) Resident care policies  28 Pa. Code 211.12(d)(1)(5) Nursing services

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>Based on observation, clinical record review, and staff and resident interview, it was determined that the facility failed to implement a physician ordered device utilized to prevent further decline in range of motion for one of five residents reviewed (Residents 5).</p> <p>Findings include:</p> <p>Clinical record review for Resident 5 revealed a current physician's order for Restorative passive range of motion (PROM) to her left upper extremity and to place a carrot in the left hand after passive range of motion was complete.</p> <p>Observation of Resident 5 on June 24, 2025, at 12:20 PM revealed she was in bed. She acknowledged that she has limited motion on her left side to include her left hand. She did not have a carrot device in her left hand during this interaction. Review of documentation revealed that PROM was completed on this date.</p> <p>Observation of Resident 5 on June 26, 2025, at 11:40 AM revealed she was out of bed in her chair, and she did not have a carrot device in her left hand. Review of documentation revealed that PROM was completed on this date.</p> <p>Concurrent interview with Resident 5 revealed that the staff had not been putting anything in her left hand for about a week or so.</p> <p>Interview of the Nursing Home Administrator on June 27, 2025, at 10:35 AM revealed that the order for the carrot device for Resident 5's left hand did not get carried through in the clinical record for the nurse aides to complete.</p> <p>483.25(c) Mobility</p> <p>Previously cited 5/3/24</p> <p>28 Pa. Code 211.12(d)(1)(5) Nursing services</p>

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>Based on clinical record review, review of facility documentation, and staff interview, it was determined that the facility failed to thoroughly investigation a resident's accident in an attempt to prevent future incidents and implement interventions to prevent falls injuries for one of five residents reviewed for falls (Resident 3).</p> <p>Findings include:</p> <p>Clinical record review for Resident 3 revealed a physician's order dated February 25, 2025, for staff to implement a tab alarm (alarm that sounds when a person moves too far away from the alarm, releasing the magnetic catch, and causing the alarm to sound) when in bed or chair and to check for function and placement every shift for safety.</p> <p>Review of facility and nursing documentation revealed that Resident 3 fell on May 1, 2025, at 4:00 PM. Resident 3 was found in his room on his knees beside the bed. The fall was unwitnessed. Resident 3 was assisted back to bed with alarms on (after the fall occurred).</p> <p>Review of a staff witness statement dated May 1, 2025, revealed that staff heard Resident 3 shouting while walking past the resident's room. They saw Resident 3 on the floor, on the ground, while holding onto the corner of the bed to keep himself upright. Staff called for the licensed practical nurse who came to Resident 3's room and requested additional help to assist with Resident 3. The witness statement did not indicate that a tab alarm was placed on Resident 3, nor did the statement indicate that any alarms were sounding at the time of the fall.</p> <p>Review of Resident 3's task documentation revealed that on May 1, 2025, the day shift (6:00 AM to 2:00 PM) staff indicated that Resident 3's tab alarm was placed and functioning at 1:44 PM. On May 1, 2025, evening shift (2:00 PM to 10:00 PM) did not assess that Resident 3's tab alarm was placed and functioning until 9:58 PM, almost six hours after Resident 3's fall.</p> <p>There was no documentation at the time of the fall that Resident 3's tab alarm was on and functioning (sounding) and no documentation that evening staff checked for function and or placement until after Resident 3's fall.</p> <p>The surveyor reviewed this information during an interview with the Director of Nursing home on June 26, 2025, at 1:57 PM</p> <p>28 Pa. Code 201.18(e)(1) Management</p> <p>28 Pa. Code 211.10(d) Resident care policies</p> <p>28 Pa. Code 211.12(d)(1)(3)(5) Nursing services</p>		

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<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide safe, appropriate pain management for a resident who requires such services.</p> <p>Based on clinical record review and staff interview, it was determined that the facility failed to provide the highest practicable care regarding physician ordered pain medications for one of three residents reviewed (Resident 32)</p> <p>Findings include:</p> <p>Review of Physiopedia's and Wikipedia's definition of the numeric pain rating scale (parameters) from zero to 10 indicated that no pain was identified as zero, mild pain was identified as one to three, moderate pain was identified as four to six, and severe pain was identified as seven to 10.</p> <p>Clinical record review for Resident 32 revealed physician's orders for the following pain medications:</p> <p>Ordered on May 3, 2025, and discontinued on May 6, 2025, Acetaminophen (Tylenol, for mild pain) 325 milligrams (mg) 2 tablets by mouth (PO) every 6 hours as needed (PRN) for pain (1-5).</p> <p>Ordered on May 5, 2025, and discontinued on May 12, 2025, Acetaminophen 325 mg 2 tablets PO every 4 hours PRN for pain (1-5).</p> <p>Ordered on May 12, 2025, Acetaminophen 325 mg 2 tablets PO every 6 hours PRN for mild pain.</p> <p>Review of Resident 32's MARs (medication administration record, a form to document medication administration) revealed the following:</p> <p>Staff administered the following PRN pain medications:</p> <p>Acetaminophen 325 mg 2 tablets PO every 6 hours PRN for pain (1-5).</p> <p>May 5, 2025, at 9:15 AM for a pain level of 9.</p> <p>Acetaminophen 325 mg 2 tablets PO every 4 hours PRN for pain (1-5).</p> <p>May 7, 2025, at 2:30 PM for a pain level of 8.</p> <p>May 8, 2025, at 4:33 AM for a pain level of 8.</p> <p>Acetaminophen 325 mg 2 tablets PO every 6 hours PRN for mild pain.</p> <p>May 22, 2025, at 4:32 AM for a pain level of 9.</p> <p>May 22, 2025, at 1:30 PM for a pain level of 8.</p> <p>May 25, 2025, at 12:10 PM for a pain level of 5.</p> <p>May 29, 2025, at 4:23 AM for a pain level of 7.</p> <p>(continued on next page)</p>

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<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>May 31, 2025, at 4:38 AM for a pain level of 8.</p> <p>June 4, 2025, at 11:30 AM for a pain level of 8.</p> <p>June 8, 2025, at 11:30 AM for a pain level of 5.</p> <p>June 12, 2025, at 4:29 AM for a pain level of 8.</p> <p>June 18, 2025, at 1:50 PM for a pain level of 7.</p> <p>The surveyor reviewed the above information during an interview with the Nursing Home Administrator and Director of Nursing on June 26, 2025, at 10:45 AM.</p> <p>28 Pa. Code 211.12(c)(d)(1)(3)(5) Nursing services</p>

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<p>F 0742</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder.</p> <p>Based on review of select facility policies, clinical record review, observation, and staff interview, it was determined that the facility failed to implement physician ordered interventions for a resident's suicidal ideations for one of one resident reviewed (Resident 31).</p> <p>Findings include:</p> <p>Review of the facility policy entitled Resident Expressing Suicidal Ideations, last reviewed on January 23, 2025, revealed it is the policy of the facility to ensure the safety of any resident that expresses the desire to harm themself.</p> <p>Clinical record review revealed that the facility admitted Resident 31 on May 30, 2025, with diagnosis of anxiety (feeling of worry, nervousness, or unease), major depressive disorder (a disorder characterized by a depressed mood, loss of interest in activities causing significant disruption in daily life), and dementia with behavioral disturbances (confusion with other symptoms such as depression, anxiety, agitation, and aggression).</p> <p>Clinical record review revealed a physician's order dated June 25, 2025, that indicated Resident 31 was to be on suicide precautions for 48 hours. Staff were to remove sharp objects from her room, and she was to have a cordless call bell. Resident 31 indicated to staff that she was going to kill herself by ripping her veins out and then she started pinching at the veins in her arms.</p> <p>Observation of Resident 31 during a medication administration pass on June 26, 2025, at 9:07 AM revealed she had a corded call bell attached to her bed, while she was in bed.</p> <p>Observation of Resident 31 on June 26, 2025, at 11:15 AM revealed she was in bed with a corded call bell attached to her sheet next to her in bed.</p> <p>Interview with Employee 5, nurse aide, who was exiting Resident 31's room on June 26, 2025, at 11:20 AM revealed that Resident 31 had thrown her call bell on the floor several times and she had to keep putting it back on the bed. Interview with Employee 4, LPN (Licensed Practical Nurse) and 5, at 11:22 AM revealed that they both were aware that Resident 31 was on suicidal precautions and that she should not have a corded call bell.</p> <p>The Nursing Home Administrator and Director of Nursing were made aware of the concerns noted above related to Resident 31's suicide precautions.</p> <p>28 Pa. Code 211.12(d)(3)(5) Nursing services</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  395350	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  06/27/2025
NAME OF PROVIDER OR SUPPLIER  Locust Grove Retirement Village		STREET ADDRESS, CITY, STATE, ZIP CODE  69 Cottage Road Mifflin, PA 17058	

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)
<p>F 0744</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia.</p> <p>Based on clinical record review and staff interview, it was determined that the facility failed to develop and implement an individualized person-centered care plan to address dementia and cognitive loss displayed by one of 3 residents reviewed (Resident 67).</p> <p>Findings include:</p> <p>Clinical record review for Resident 67 revealed the facility admitted her on November 19, 2024, with a diagnosis including Dementia (loss of memory, language, problem-solving, and other thinking abilities that interfere with daily life).</p> <p>A review of Resident 67's current care plan entitled, Impaired cognitive function or impaired though processes related to dementia revealed that there was no indication that the facility had implemented an individualized person-centered care plan to address the resident's dementia and cognitive loss needs.</p> <p>The findings were reviewed with the Nursing Home Administrator and Director of Nursing on June 27, 2025, at 12:10 PM.</p> <p>483.40(b)(3) Dementia Treatment and Services</p> <p>Previously cited 05/03/24</p> <p>28 Pa Code 211.12 (d)(1)(3)(5) Nursing services</p>