

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395366	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/02/2025
NAME OF PROVIDER OR SUPPLIER Pine Run Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE 777 Ferry Road 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)
<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>Based on clinical record review, policy review, review of facility documentation, and staff interview, it was determined that the facility failed to ensure that a licensed practical nurse (LPN) maintained professional standards of quality care in following the established policies and procedures of the facility set forth in the Pennsylvania Code Title 49 Professional and Vocational standards for one of three sampled residents who were at risk for falls. (Resident 1) Findings include: Review of Pennsylvania Code Title 49, Chapter 21, Subchapter B. Practical Nurses, revealed guidelines which included that an LPN shall follow the written, established policies and procedures of the facility. Review of the facility policy entitled, Falls Management Program, last reviewed January 2025, revealed that when a resident sustained a fall, an examination by a licensed nurse was completed and a Registered Nurse (RN) must assess the resident post fall and document on the accident/incident report. Clinical record review revealed that Resident 1 had diagnoses that included orthostatic hypotension, history of stroke, and glaucoma. On September 13, 2025, LPN 1 noted that Resident 1 was found on the floor after a fall, the RN supervisor was notified but did not assess the resident, and the resident was placed back into his chair by LPN 1. Review of facility documentation indicated that the resident's family and physician were notified of the fall. There was no evidence in the clinical record or facility documentation that Resident 1 was assessed by an RN after the fall. In an interview on November 10, 2025, at 3:02 p.m., the Director of Nursing stated that LPN 1 did not directly notify the RN supervisor of the fall, LPN 1 should not have transferred the resident before an RN assessment, and Resident 1 was not assessed by an RN after the fall. 28 Pa. Code 211.10(c) Resident Care Policies. 28 Pa. Code 211.12(d)(1)(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 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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, observation, staff interview, and review of facility policy, it was determined that the facility failed to safely administer medications for one of 14 sampled residents. (Resident 2) Findings include: Review of the facility policy entitled, Medications, Administration (Self), last reviewed January 2025, revealed that a written physician's order for self-administration of medications and bedside storage was obtained and kept in the resident's medical record. Clinical record review revealed that Resident 2 had diagnoses that included muscle wasting, dysphagia, need for assistance with personal care, and hearing loss. Review of the resident's self-administration of medications assessment dated [DATE], revealed that she required assistance storing medications in a secured location, administering oral medications, naming medications and prescribed use, and she was not approved to self-administer her own medications. On November 10, 2025, at 11:10 a.m., Resident 2 was observed in her room and there was a cup of medications on her bedside table. In an interview at that time, nurse aide (NA) 1 stated that the cup contained the resident's morning medications. There was a lack of evidence to support that Resident 2 had a physician's order to self-administer medications. In an interview on November 10, 2025, at 3:57 p.m., the Director of Nursing confirmed that Resident 2 did not have a physician's order to self-administer medications. 211.10(d) Resident care policies. 211.12(d)(1)(5) Nursing services.</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>Based on facility policy review and observation, it was determined that the facility failed to follow policies and procedures to prevent the spread of infection on the nursing unit. (Fourth floor) Findings include: Review of the facility policy entitled, Hand Hygiene, last reviewed January 2025, revealed that staff was to sanitize or wash their hands before and after each procedure or task and after handling resident belongings. On November 10, 2025, at 11:50 a.m., nurse aide (NA) 2 was observed exiting Resident 3's room carrying linens with ungloved bare hands. NA 2 disposed of the linens into the dirty linen receptacle. NA 2 did not perform hand hygiene after this task and proceeded to enter Resident 4's room without performing hand hygiene. NA 2 touched Resident 4's belongings, obtained clean linens from the clean linen cart, re-entered then exited Resident 4's room again, and did not perform hand hygiene at any time during the observation.28 Pa. Code 211.10(b)(d) Resident care policies. 28 Pa. Code 211.12(d)(1)(5) Nursing services.</p>