STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395366	A. Building B. Wing	03/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pine Run Health Center	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)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 43883 Based on clinical record review and observation, it was determined that the facility failed to ensure that dignity was maintained for two of 18 sampled residents. (Residents 45, 222) Findings include: Clinical record review revealed that Resident 45 had diagnoses that included stroke, hemiplegia to the left side, depression, and muscle weakness. Review of the care plan revealed that the resident preferred activities that identified with his prior lifestyle and staff were to include the resident's preferences in rendering care and services. On March 19, 2024, at 1:33 p.m., Resident 45 was observed in bed. The white board on the wall in his room displayed March 11, 2024, and identified an assigned nurse and nurse aide for that date. During the observation, the resident stated that he preferred the white board to be updated daily with accurate and current information and he does not recall the last time staff updated the board. Observations on March 20, 2024, at 11:52 a.m., and March 21, 2024, at 11:20 a.m., revealed that the resident's white board still displayed March 11, 2024, with the same staff names. Clinical record review revealed that Resident 222 had diagnoses that included obstructive uropathy (a disorder of the urinary tract that occurs due to obstructed urinary flow) and neurogenic bladder (lack of bladder control due to brain, spinal cord or nerve problems). Resident 222 was ordered by the physician to utilize a foley catheter for urination. Observations on March 19, 2024, from 11:04 a.m. through 1:00 p.m., and March 21, 2024, from 10:39 a.m. through 11:15 a.m., revealed Resident 222 sitting in a wheelchair in the common area. The foley catheter bag was not covered and contained urine. Multiple residents and staff were present in the same area during those time periods. During an interview on March 22, 2024, at 10:49 a.m., the Director of Nursing confirmed that Resident 222 had a foley catheter without a dignity bag. 28 Pa. Code 211.12(d)(1)(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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0623 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. 43883 Based on clinical record review and staff interview, it was determined that the facility failed to notify the resident and the resident's representative(s) of transfer(s) in writing upon transfer from the facility for two of two sampled residents who were transferred to the hospital. (Residents 2, 23) Findings include: Clinical record review revealed that Resident 2 was transferred and admitted to the hospital on December 30, 2023, after a change in condition. There was no documentation to support that the resident and/or the resident's responsible party or legal representative was provided written information regarding the transfer to the hospital. Clinical record review revealed that Resident 23 was transferred and admitted to the hospital on March 6, 2024, after a change in condition. There was no documentation to support that the resident and/or the resident's responsible party or legal representative was provided written information regarding the transfer to the hospital. In an interview on March 22, 2024, at 10:36 a.m., the Assistant Administrator confirmed that written notice regarding transfer from the facility was not provided.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
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. 45244 Based on clinical record review and staff interview, it was determined that the facility failed to ensure that physician's orders were implemented for one of 18 sampled residents. (Resident 15) Findings include: Clinical record review revealed that Resident 15 had diagnoses that included pleural effusion, dysphagia (difficulty swallowing), and lymphedema. Review of the care plan revealed that Resident 15 was at risk for dehydration and weight changes and staff were to monitor weights and report changes to the physician. On November 17, 2023, the physician ordered for the resident to be weighed daily. There was no evidence that weights were obtained on March 4, 7, 9, and 17, 2024. On January 19, 2024, there was an order for staff to notify the physician of a two pound (lb.) weight gain or loss in one day or a five lb. weight change in one week. Review of the resident's weight record revealed that she experienced weight changes of greater than two pounds in one day on the following dates: A loss of 3.6 lbs. from January 31, 2024, through February 1, 2024. A gain of 3.6 lbs. from February 15 through 16, 2024. A loss of 3.8 lbs. from February 18 through 19, 2024. A gain of 4.2 lbs. from February 19 through 20, 2024. A loss of 4.4 lbs. from February 20 through 21, 2024. A gain of 2.6 lbs. from February 26 through 27, 2024. A loss of 4.8 lbs. from March 5 through 6, 2024. There was no evidence that the physician was notified of the weight loss or increase of greater than two lbs. in one day as ordered. In an interview on March 22, 2024, at 11:08 a.m., the Director of Nursing confirmed that Resident 15's weights were not obtained as ordered and that the doctor was not notified of the weight changes as ordered. 28 Pa. Code 211.12(d)(1)(5) Nursing services.

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(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. 43883 Based on observation, it was determined that the facility failed to store food under sanitary conditions in the kitchen. Findings include: Observation of the kitchen on March 19, 2024, at 11:50 a.m. revealed the following: The bottom row of shelves in the reach-in freezer were missing. Multiple food items were stored on the bottom floor of the freezer. There was a box of raw chicken cheesesteak meat that was open, other food items were stored on top of the box. There was an open bag of French fries that was not dated. The slicer handle was broken. There was a muffin tin and round cake pan stored on top of a transformer. There were two muffin tins on the floor between the storage shelf and the transformer. There was water leaking from the nozzle of a hose behind the kettle while food was being cooked. There was an accumulation of debris under the stovetop and grille. There was cocktail sauce with a use-by date of March 15, 2024, and blue cheese dressing with a use-by date of March 16, 2024, in the walk-in refrigerator. There was a container of popcorn with a use-by date of January 23, 2024, in dry storage. There were two trays of croquettes in the walk-in freezer that were not completely sealed and were open to air. 28 Pa. Code 201.18(b)(3)(e)(2.1) Management.