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	03/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pine Run Health Center	777 Ferry Road Doylestown, PA 18901

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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. Based on 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 and in two of three country kitchens. (Second and Third floors) Findings include:Observations during the tour of the dietary department and in the country kitchen on the second floor on March 10, 2026, at 10:25 a.m., revealed the following:In the Emergency Food Storage section, there was one box of six large cans of green beans that was expired on December 25, 2025, nine cans of corned beef that were labeled with a use by date of July 1, 2025, four large boxes of oatmeal that were labeled with a use by date of September 8, 2025, four large boxes of apple juice dated use by date of December 9, 2025, two large boxes of cranberry juice that were labeled with a use by date of October 16, 2025, six large cans of tomatoes labeled with a use by date of June 17, 2025, and six large cans of fruit cocktail that were noted to be expired on May 28, 2025.In the country kitchen on the second floor, there was a container of half a gallon milk with a use by date of March 7, 2026. There was a container of grape tomatoes that was not dated. In an interview on March 10, 2026, at 10:45 a.m., the Dining Services Assistant Director confirmed the expired foods should have been removed in the Emergency Food Storage and in the second floor country kitchen and that they were not. Review of the facility's policy entitled, Uniform Standards, dated March 1, 2026, revealed that all staff was to cover all of their hair with a hair and/or beard restraint in all food service areas. Observation during lunch meal service in the country kitchen on the third floor on March 11, 2026, from 12:00 p.m. to 12:30 p.m., revealed Dietary Employee (DE) 1 was serving and plating food with hair and facial hair that was not covered. 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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, group interview, resident interviews, and review of electronic call bell logs, it was determined that the facility failed to answer call bells in a timely manner to provide care and services respectful of each resident's dignity and preferences to promote the quality of life for six of 18 sampled residents. (Residents 3, 6, 56, 68, 83, 96)Findings include:Review of the facility policy entitled Call Bell Response, dated January 5, 2026, revealed that all nursing personnel must be aware of call lights/alerts at all times, and answer bell/alert promptly. During an interview on March 11, 2026, at 1:17 p.m., the Administrator stated that staff were expected to respond to call bells in less than 20 minutes. Clinical record review revealed that Resident 3 had diagnoses that included chronic kidney disease and recovery from recent digestive system surgery. The Minimum Data Set (MDS) assessment dated [DATE], indicated that the resident was able to communicate his needs to staff and required assistance from staff for activities of daily living such as toileting and dressing. Clinical record review revealed that Resident 6 had diagnoses that included congestive heart failure, diabetes and recovery from recent limb surgery. The MDS assessment dated [DATE], indicated that the resident was able to communicate her needs to staff and required extensive assistance from staff for transfers and activities of daily living such as toileting and dressing.Clinical record review revealed that Resident 56 had diagnoses that included chronic kidney disease and recovery from hip replacement surgery. The MDS assessment dated [DATE], indicated that the resident was able to communicate her needs to staff and required assistance from staff for transfers and activities of daily living such as toileting and dressing. Clinical record review revealed that Resident 68 had diagnoses that included chronic kidney disease and congestive heart failure. The MDS assessment dated [DATE], indicated that the resident was able to communicate her needs to staff and required extensive assistance from staff for transfers and activities of daily living such as toileting.Clinical record review revealed that Resident 83 had diagnoses that included heart disease, chronic kidney disease, and recovery from wounds on his feet. The MDS assessment dated [DATE], indicated that the resident was able to communicate his needs to staff and required extensive assistance from staff for transfers and activities of daily living such as toileting.Clinical record review revealed that Resident 96 had diagnoses that included congestive heart failure and recovery from recent spinal surgery. The MDS assessment dated [DATE], indicated that the resident was able to communicate his needs to staff and required extensive assistance from staff for transfers and activities of daily living such as toileting and dressing.During a confidential group interview on March 11, 2026, at 10:00 a.m., seven residents reported that it often took 30 minutes or more for staff to answer their call bells and get assistance.Review of the facility form entitled, Device Activity Report, for Residents 3, 6, 56, 68, 83, 96 from February 10, 2026, through March 10, 2026, revealed that there were 87 occurrences when the call bell response time exceeded 20 minutes which included: March 7, 2026, at 4:42 a.m., when Resident 3 waited 96 minutes; February 14, 2026, at 11:33 a.m., when Resident 6 waited 125 minutes; February 22, 2026, at 12:07 p.m., when Resident 56 waited 38 minutes; March 4, 2026, at 8:27a.m., when Resident 68 waited in the bathroom for 93 minutes; March 1, 2026 at 10:31 am., when Resident 83 waited 130 minutes; and March 7, 2026, at 9:53 a.m., when Resident 96 waited 109 minutes.During an interview on March 11, 2026, at 1:17 p.m., the Administrator confirmed that the aforementioned residents waited more than the expected response time of 20 minutes. 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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 implement physicians' orders for six of 21 sampled residents. (Residents 3, 11, 29, 37, 42, and 56) Findings include: Clinical record review revealed that Resident 3 had diagnoses that included hypotension (low blood pressure) and chronic kidney disease. A physician's order dated February 26, 2026, directed staff to administer 5 milligrams (mg) of a blood pressure medication (midodrine) two times daily. The physician ordered that staff was not to administer the 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 higher than 130 millimeters of mercury (mm/Hg). Review of Resident 3's Medication Administration Record (MAR) for February and March 2026, revealed that the staff withheld the medication once in February, when Resident 2's blood pressure was below 130mm/Hg and administered midodrine once in March, when Resident's 3's SBP was higher than 130 mm/Hg. Clinical record review revealed that Resident 11 had diagnoses that included heart failure and kidney disease. On February 2, 2026, the physician ordered that staff weigh the resident every Monday and Thursday and to notify the physician of weight gain greater than two pounds between weights or five pounds in a week. Review of Resident 11's February and March 2026, Treatment Administration Records revealed no evidence that staff weighed Resident 11 on February 5 and March 5, 2026. Clinical record review revealed that Resident 29 had diagnoses that included hypertension. On January 4, 2026, the physician ordered staff to administer a medicine (hydralazine) two times a day as needed for hypertension. Staff was to administer the medication if the resident's SBP was greater than 160 millimeters of mercury (mm/Hg) or if the diastolic blood pressure (DBP, is the pressure in the pressure in the arteries when the heart is relaxed and filling with blood between beats) was greater than 90. Review of Resident 29's February and March 2026 MAR revealed that staff administered the hydralazine 17 times in February and five times in March, when the resident's SBP was less than 160 mm/Hg or the DBP was less than 90 mm/Hg. Clinical record review revealed that Resident 37 had diagnoses that included dementia and diabetes. A physician's order dated December 19, 2025, directed staff to administer 30 milliliters (ml) of milk of magnesia for constipation on day four if the resident had no bowel movement in the previous three days. A physician's order dated December 19, 2025, directed staff to administer a Dulcolax suppository as needed for constipation if the milk of magnesia was ineffective and to give it to the resident on day five. A physician's order dated December 19, 2025, directed staff to administer a Fleet Saline Enema as needed for constipation if the Dulcolax suppository was ineffective and to give it to the resident on day six. Review of bowel movement tracking documentation for Resident 37 revealed that there were no bowel movements recorded from December 24, 2025, through January 2, 2026, and January 13, through January 18, 2026. Review of the MAR for December 2025 and January 2026, revealed that the resident was not provided the milk of magnesia, suppository and/or the enema as ordered. Clinical record review revealed that Resident 42 had diagnoses that included dementia and diabetes. A physician's order dated June 3, 2025, directed staff to administer 30 ml of milk of magnesia for constipation on day four if the resident had no bowel movement in the previous three days. A physician's order dated June 3, 2025, directed staff to administer a Dulcolax suppository as needed for constipation if the milk of magnesia was ineffective and to give it to the resident on day five. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of bowel movement tracking documentation for Resident 42 revealed that there were no bowel movements recorded from November 25 through 30, 2025. Review of the MAR for November 2025, revealed that the resident was not provided the milk of magnesia, and/or the suppository as ordered. Clinical record review revealed that Resident 56 had diagnoses that included hypertension (high blood pressure) and chronic kidney disease. A physician's order dated February 26, 2026, directed staff to administer 20 mg of a blood pressure medication (Furosemide), along with one 20 milliequivalent (mEq) tablet of potassium chloride, once daily as needed for SBP greater than 160 mm/Hg. Review of Resident 3's MAR for February and March 2026, revealed that the staff withheld the medication three times in February and twice in March, when Resident 56's blood pressure was above 160 mm/Hg. A physician's order dated March 9, 2026, directed staff to administer 12.5 mg of a blood pressure medication (hydrochlorothiazide) to Resident 56 once daily as needed for SBP greater than 160 mm/Hg. Review of Resident 3's MAR for March 2026, revealed that the staff withheld the medication once when Resident 56's blood pressure was above 160mm/Hg. A physician's order dated March 10, 2026, directed staff to administer 25 mg of a blood pressure medication (hydralazine) twice daily to Resident 56. The physician ordered that staff were not to administer the medication if the resident's SBP was lower than 130 mm/Hg. Review of Resident 56's MAR for March 2026 revealed that the staff administered the medication once when Resident 56's blood pressure was below 130mm/Hg. In an interview on March 12, 2026, at 9:52 a.m., the Director of Nursing confirmed that nursing was to follow the physicians' orders and that there was no documented evidence that Resident 11 was weighed in accordance with the physician's order. 28 Pa. Code 211.12(d)(1)(5) Nursing services.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and interview, it was determined that the facility failed to provide restorative nursing services to improve or maintain walking mobility on a consistent basis for one of 21 sampled residents. (Resident 4) Findings include:Clinical record review revealed that Resident 4 had diagnoses that included Alzheimer's disease, generalized muscle weakness, and difficulty in walking. The Minimum Data Set assessment dated [DATE], indicated that the resident was cognitively impaired and required limited assistance from staff for activities of daily living. On February 10, 2026, the physical therapist had recommended a Restorative Nursing Program (RNP) for walking with a rolling walker for ambulation up to 200 feet. In an interview on March 12, 2026, at 12:37 p.m., the Director of Therapy stated the program consisted of Resident 4 using a front wheeled walker to go to and from the dining room for each meal and that it was to maintain his mobility status. There was a lack of documentation to support that the resident was offered restorative ambulation on eight of 30 days.In an interview on March 12, 2026, at 12:15 p.m., the Nursing Home Administrator confirmed that there was no documented evidence that Resident 4 was offered the restorative nursing program daily and it should have been.28 Pa. Code 211.12(d)(1)(5) Nursing services.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, clinical record review, staff interview, and review of facility policy it was determined that the facility failed to store respiratory equipment appropriately for one of three sampled residents who received oxygen therapy. (Resident 42) Findings include: Review of the facility policy entitled, Oxygen Protocol, dated January 5, 2026, revealed that oxygen cannulas and masks were to be changed weekly and labeled with the date. When oxygen tubing was not in use it was to be kept in a plastic bag. Staff were to place a new bag with the resident's name and date on the side of the concentrator or portable oxygen tank weekly to hold the tubing. Clinical record review revealed that Resident 42 had diagnoses that included chronic obstructive pulmonary disease and respiratory failure. On September 5, 2025, the physician ordered that staff administer oxygen therapy via nasal cannula (a tube with two prongs where each prong is inserted into each nostril of the nose) at a rate of two liters per minute at bedtime. On September 5, 2025, the physician ordered for staff to administer oxygen therapy via nasal cannula as needed. Observations on March 10, 2026, at 11:50 a.m., and 12:45 p.m., revealed the resident seated in her wheelchair with a portable oxygen tank in the back pouch with an attached nasal cannula. The oxygen was not in use, and the tubing was not dated and was not stored in the attached storage bag. Observations on March 10, 2026, at 11:05 a.m., and 1:21 p.m., revealed a second set of oxygen tubing that was not dated and attached to the oxygen concentrator in the resident's room. The tubing was not in use and was not stored in the storage bag attached to the oxygen concentrator. An observation on March 11, 2026, at 8:25 a.m., revealed the oxygen tubing attached to the oxygen concentrator in the resident's room was not in use and was not stored in the storage bag. During an interview on March 12, 2026, at 10:04 a.m., the Director of Nursing confirmed that the oxygen cannula and tubing should have been dated and placed in a bag when not in use. 28 Pa. Code 211.12 (d)(5) Nursing services.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. Based on clinical record review and staff interview, it was determined that the facility failed to ensure that the physician acknowledged the pharmacist's recommendations for two of 21 sampled residents. (Residents 9 and 37)Findings include: Clinical record review revealed that on September 14, 2025, the consultant pharmacist made a recommendation to review and assess the orders for Resident 9's Celexa and Remeron. On November 17, 2025, the consultant pharmacist made a recommendation to evaluate and adjust the dose of Tylenol. There was no documented evidence that the attending physician had acknowledged or acted upon these recommendations. Clinical record review revealed that on December 24, 2025, the consultant pharmacist made recommendations to evaluate Resident 37's seroquel for a dose reduction and to consider adding a stimulant laxative such as Senna to this resident's regiment to prevent constipation. On January 13, 2026, the consultant pharmacist again made recommendations to evaluate Resident 37's seroquel. There was no documented evidence that the attending physician had acknowledged or acted upon these recommendations. In an interview on March 12, 2026, at 10:07 a.m., the Director of Nursing confirmed that the medication review recommendations were not addressed by the physician. 28 Pa. Code 211.12(d)(3)(5) Nursing services.

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F 0628 Level of Harm - Potential for minimal harm Residents Affected - Many	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 that the facility failed to notify the resident and/or the resident's representative of their appeal rights and the contact information for the Office of the State Long-Term Care Ombudsman in writing upon transfer from the facility for six of six sampled residents who were transferred to the hospital. (Residents 2, 3, 7, 8, 10 and 11) Findings include: Clinical record review revealed that Resident 2 was transferred to the hospital on January 28, 2026, after a change in condition. There was no documented evidence that the resident, the resident's responsible party, or the legal representative was provided information regarding appeal rights and contact information for the Office of the State Long-Term Care Ombudsman upon transfer to the hospital. Clinical record review revealed that Resident 3 was transferred to the hospital on January 13, 2026, after a change in condition. There was no documented evidence that the resident, the resident's responsible party, or the legal representative was provided information regarding appeal rights and contact information for the Office of the State Long-Term Care Ombudsman upon transfer to the hospital. Clinical record review revealed that Resident 7 was transferred to the hospital on March 9, 2026, after a change in condition. There was no documented evidence that the resident, the resident's responsible party, or the legal representative was provided information regarding appeal rights and contact information for the Office of the State Long-Term Care Ombudsman upon transfer to the hospital. Clinical record review revealed that Resident 8 was transferred to the hospital on December 13, 2025, after a change in condition. There was no documented evidence that the resident, the resident's responsible party, or the legal representative was provided information regarding appeal rights and contact information for the Office of the State Long-Term Care Ombudsman upon transfer to the hospital. Clinical record review revealed that Resident 10 was transferred to the hospital on January 17, 2026, February 22, 2026, and March 3, 2026, after changes in conditions. There was no documented evidence that the resident, the resident's responsible party, or the legal representative was provided information regarding appeal rights and contact information for the Office of the State Long-Term Care Ombudsman upon transfer to the hospital. Clinical record review revealed that Resident 11 was transferred to the hospital on December 27, 2025, after a change in condition. There was no documented evidence that the resident, the resident's responsible party, or the legal representative was provided information regarding appeal rights and contact information for the Office of the State Long-Term Care Ombudsman upon transfer to the hospital. In an interview on March 11, 2026, at 1:20 p.m., the Administrator confirmed that the identified residents and/or their representatives were not provided with transfer notices that included the required information.