

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

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395370	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/21/2025
NAME OF PROVIDER OR SUPPLIER Luther Woods Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 313 County Line Road Hatboro, PA 19040	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Dispose of garbage and refuse properly. Based on observations and an interview with staff it was determined that the facility did not ensure that garbage and refuse was disposed of properly. Findings include: Observations in the receiving area conducted on November 18, 2025, at approximately 10:30 a.m. revealed piles of leaves covering multiple wooden pallets. Empty cans, dirty napkins, and cardboard boxes were observed mixed within the leaves. Further observations in the trash area revealed that the compactor and recycling containers were open, and black trash bags were exposed without lids. Furniture, including couches and chairs, was piled in the same area, with one couch positioned between the compactor and recycling box. Interview with Food Service Director, Employee E14 along duration of the tour confirmed observations of the receiving and dumpster area. 28 Pa. Code 201.18(b)(1) Management 28 Pa. Code 201.18(b)(3) Management		

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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. Based on review of facility policy, staff and resident interviews, and observation, it was determined that the facility did ensure a formal grievances process was in place for two of three units observed. (A Wing, B Wing). Findings Include: Review of the facility policy titled Grievances dated January 23, 2020 states, Policy- the patient has the right to voice/file grievances/complaints (orally, in writing or anonymously) without fear of discrimination or reprisal. The Administrator serves as the grievance official of the Center and is responsible for overseeing the grievance process and for receiving and tracking to their conclusion. A tour was taken with the facility Social Worker, Employee E9 on November 19, 2025 to identify where postings and grievance paperwork was located for residents. During the tour it was observed that A wing was missing grievance forms, the statement regarding the grievance process, and department of health posting information. A tour of B Wing revealed missing grievance forms, the statement regarding the grievance process, and department of health posting information. Social Worker, Employee E9 stated they no longer had the grievance forms available for residents or visitors on those units and could not specify how long they have not been up. In the lobby area there was one location where grievance forms were able to be found, but there was no posting about the grievance process, who the grievance official was, or how to form a grievance anonymously. A tour was taken on November 20, 2025 at 3:02 p.m. with Employee E1 the Nursing Home Administrator and it was confirmed the only place where the grievance forms were available was in the front lobby. When asked about the posting about how to form a grievance and who the grievance official was, Employee E1 stated, I didn't know there had to be something like that and I am the grievance official they can give the form to me, the social worker Employee E9, or place it in the box in the chapel. The box for anonymous grievances was observed in the chapel, and it was a box that was completely clear and not locked. The box currently being used would not be appropriate to allow to anonymous grievances as it is completely clear to access private information to anyone who enters the chapel. This was confirmed with the Nursing Home Administrator Employee E1. The facility did not have any postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing, the right to file grievances anonymously, the contact information of the grievance official with whom a grievance can be filed including, business address (mailing and email) and business phone number, a reasonable expected time frame for completing the review of the grievance, the right to obtain a written decision regarding his or her grievance, and the contact information of independent entities with whom grievances may be filed. Review of the facility Resident Council minutes dated September 26, 2025 states, Resident Rights Review- our grievance officer is Employee E9, our Social Worker. She will complete the grievance form with you and report to the Management Team and Investigate the issue. Grievance reports are completed within three days with the exception of missing items which is one month to allow time to search for the item. Employee E9 will report back to the resident and/or family when the report is closed. Interview held with awake, alert, and oriented residents on November 20, 2025 and some residents had concerns about the grievance process. Six residents (Resident R1, R5, R24, R73, R149, and R150) stated that they were unsure about the formal grievance process or who the grievance official was. Some stated it was the social worker, some thought the nurse manager, and others thought the nursing home administrator. Interview held with the Nursing Home Administrator at 11:05 a.m. on November 21, 2025 confirmed that during Resident Council it was reviewed that residents could come to either me or {Social Worker, Employee E9}. 28 Pa. Code 201.18(b)(2) Management 28 Pa. Code 201.29(a)(i) Resident rights		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, review of facility policy and interviews with staff, it was determined that the facility did not ensure that food was stored, prepared, distributed, and served in accordance with professional standards for food service safety. Findings include: Review of facility policy titled, Cleaning dishes/Dish Machine undated, indicated that staff must check the dish machine gauges throughout the cycle to assure proper temperatures and sanitation. Observations conducted on November 18, 2025, at 10:12 a.m. revealed while the low-temperature dish machine was running, a review of the sanitizer ppm test strip with the Food Service Director (FSD), Employee E 14 revealed no color change, indicating no chlorine present. The acceptable range is 50-100 ppm. A second and third recheck were completed 3-5 minutes later with no change in color. Interview with dietary staff, Employee E15, revealed that she has been performing this task for 1-2 weeks, at least once per day, and does not check the chlorine when completing the dish machine task during her shift. Further observation of the dish room revealed it was not maintained in a sanitary condition. The soiled side of the dish room contained visible food debris on the counters and sink, and the prerinse station had buildup grime around the drain and backsplash. The floor in the area had scattered food particles, visible black dirt, and areas of black grime and residue. Mold or blackened residue was observed along the wall side up towards the dining room doors. The overall condition did not reflect routine cleaning practices. Interview with the Food Service Director, Employee E5, throughout the kitchen tour confirmed the above-mentioned findings. 28 Pa. Code 201.14(a) Responsibility of licensee		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, observations, review of clinical records, and interviews with staff and residents it was determined that the facility did not ensure to develop and implement comprehensive person-centered care plans for each resident and develop goals and interventions related to residents refusals, behaviors and residents diagnosed with Dementia, and PTSD for five of 26 resident records reviewed (Residents R3, R10, R11, R19, R136). Findings include: Review of facility policy titled Care Planning with a date of November 1, 2019 states, Policy- a licensed nurse, in coordination with the interdisciplinary team, develops and implements an individualized care plan for each patient in order to provide effective, person-centered care, and the necessary health-related care and services to attain or maintain the highest practical physical, mental, and psychosocial well-being of the patient. Further review of the policy revealed, .5. Care plans will be updated on an ongoing basis as changes in the patient occur and reviewed quarterly with the quarterly assessment. Review of the facility's policy titled, Care planning dated November 2019, states that the facility, Develops and implements an individualized care plan for each patient in order to provide effective person-centered care, and the necessary health-related care and serviced to attain or maintain the highest practical physical, mental and psychosocial well-being of the patient. Review of the facility's policy titled, Trauma Informed Care dated January 2020, states that the facility, Recognizes and acknowledges that residents who are trauma survivors may experience emotional, physical and/or psychological difficulties that should be addressed immediately, The same policy states, Immediately update the care plan to reflect information about trauma gathered from the patient. Resident R19 was admitted to the facility on [DATE], diagnosed with anxiety, major depression, and psychotic and mood disturbances (mental health diseases). Review of the facility's Trauma Informed assessment dated [DATE], for Resident R19 indicated the resident experienced domestic abuse and gun violence when the resident was previously shot in the leg. Review of a facility reported incident stated on July 16, 2025, Resident R19 was Found on the floor of her room lying next to her bed. The resident told staff that she had been having a nightmare/PTSD (post-traumatic stress disorder is a mental health condition that's caused by an extremely stressful or terrifying event - symptoms may include flashbacks, nightmares, severe anxiety about the event.) The resident sustained a small laceration on the resident's head at was sent to the hospital. Review of Resident R19 care plan revealed the PTSD incident focused on the fall not the actual PTSD. This was confirmed with the Director of Nursing on November 20, 2025, at 4:00 pm. that the facility failed to develop an appropriate care plan for the resident's PTSD. Review of Resident R136's clinical record revealed the resident was admitted to the facility on [DATE] with the following diagnoses: Paraplegia (paralysis of the legs and lower body), Dementia with behavioral disturbances and mood disturbance (neuropsychiatric symptoms that accompany the syndrome of dementia, such as delusions, hallucinations, apathy, anxiety, depression, or disinhibition), lack of coordination (uncoordinated movement is due to a muscle control problem that causes an inability to coordinate movements), and Anxiety (an emotion characterized by apprehension and somatic symptoms of tension). Review of facility clinical progress notes for Resident R136 revealed the resident has been having aggressive behaviors (hitting) staffing and refusals as follows: September 6, 2025 note revealed, I asked resident if it was ok to complete his flush and he said okay. When I pulled the covers back he smacked my hand and told me to stop, get off of me. September 8, 2025 note reads, refused flush when I asked could complete it and asked me to get out. Review of Resident R136's physician order revealed a current order with an initial date of October 17, 2025, for paired care. Review of resident R136's current care plan dated September 15, 2025 did not include current goals or interventions to address Resident R136's aggressive behaviors (hitting) and refusals of medical care. Review of nursing notes and documented diagnoses for Resident R11, revealed that the resident was (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	being followed by a psychiatrist and had a documented diagnosis of PTSD. Review of care plan revealed no care plan addressing Resident R11's PTSD, despite this diagnosis being noted in the hospital records dated January 4, 2025. Interview with the Director of Nursing, conducted on November 21, 2025, at 12:41 p.m. confirmed that no care plan for PTSD had been developed for Resident R11. A review of Physician Orders for Resident R3 revealed that the resident was ordered daily weights due to chronic systolic congestive heart failure, and nightly CPAP (a therapy device that delivers continuous air pressure to help individuals with sleep apnea breathe more easily during sleep). Review of the Medication and Treatment Administration documentation for the months of September, October, and November 2025 showed repeated refusals of both the daily weights and CPAP therapy. Progress notes dated August 17, 2025, indicated, MD (physician) notified of chronic refusals, and staff documented that they were unable to encourage compliance. Review of Resident R3's current care plan showed that no refusals care plan of individualized interventions was developed to address the ongoing noncompliance. Interview with the Director of Nursing, conducted on November 21, 2025, at 12:34 p.m. confirmed that there was no refusal care plan in place for Resident R3. Review of Resident R10's admission documentation revealed that Resident R10 was admitted in the facility on October 1, 2022, with the diagnosis of unspecified dementia (progressive degenerative disease of the brain). Review of Resident R10's current plan of care revealed that there was no care plan developed for Dementia Care. On November 20, 2025, at the time of the finding interview with the Director of Nursing confirmed the same. Review of Resident R84's admission documentation revealed that Resident R84 was admitted in the facility on May 2, 2022, with the diagnosis of Post-Traumatic Stress Disorder (PTSD). Review of Resident R84's current care plan revealed no care plan developed for Post-Traumatic Stress Disorder Care. On November 20, 2025, at the time of the finding interview with the Director of Nursing confirmed the same. 28 Pa. Code 211.10(c)(d) Resident care policies 28 Pa. Code 211.12(d)(1)(5) Nursing services		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Falling under Comprehensive Resident Centered Care Plan- The facility did ensure services provided met professional standards related to medication administration for one resident.Number of residents sampled: Number of residents cited: Findings include: The Pennsylvania Code, Title 49, Professional and Vocational Standards, State Board of Nursing, 21.11(b), General Functions of the Registered Nurse (RN), and 21.14(a), Administration of Drugs, indicated that the RN is fully responsible for all actions as a licensed nurse and is accountable to patients for the quality of care delivered, and administers medication ordered for the patient in the dosage and manner prescribed. The Pennsylvania Code, Title 49, Professional and Vocational Standards, State Board of Nursing, 21.145(a)(b), Functions of the Licensed Practical Nurse (LPN), indicated that the LPN functions as a member of the health-care team by exercising sound nursing judgement based on preparation, knowledge, experience in nursing and competency, and administers medication ordered for the patient. Review of Resident R3's clinical record revealed the resident was admitted to the facility on [DATE], with a diagnosis of Anemia (condition in which the blood doesn't have enough healthy red blood cells) and Chronic Kidney Disease (Longstanding disease of the kidneys leading to renal failure). Review of Resident R3's clinical record revealed an order dated September 21, 2025, for Fluticasone-Salmeterol 100-50 MCG/ACT Aerosol Powder, breath activated, give 1 puff by mouth every 12 hours for Chronic Obstructive Pulmonary Disease related to Acute Chronic Diastolic (Congestive) Heart Failure. Observation on November 19, 2025, at 9:12 a.m., of Employee E13, a Licensed Nurse, administering medications to Resident R3, revealed that Licensed nurse, Employee E13 gave 1 puff of Fluticasone-Salmeterol 100-50 MCG/ACT Aerosol Powder, by the mouth to Resident R3. Resident R3 was no observed rinsing (his/her) mouth after inhaling Fluticasone-Salmeterol. It was observed that Licensed nurse, Employee E13 did not encourage or educate Resident R3 to rinse (his/her) mouth after inhaling Fluticasone-Salmeterol to prevent the side effects of the Fluticasone-Salmeterol 100-50 MCG/ACT Aerosol Powder. Review of Resident R14's clinical record revealed the resident was admitted to the facility on [DATE], with a diagnosis of Chronic Obstructive Pulmonary Disease, COPD, (A condition caused by damage to the airways or other parts of the lung. This damage leads to inflammation and other problems that block airflow and make it hard to breathe), and Endocarditis (Inflammation of the endocardium - the inner lining of the heart chambers and valves. Endocarditis is a life-threatening disease. In endocarditis, clumps of bacteria or fungi from another part of your body get into your bloodstream and collect on the endocardium). Review of Resident R14's clinical record revealed an order dated July 15, 2024, for Trelegy Ellipta Inhalation Aerosol Powder Breath Activated 100-62.5-25 MCG/ACT (Fluticasone-Umeclidinium-Vilanterol), 1 puff inhale orally one time a day related to Chronic Obstructive Pulmonary Disease. Observation on November 19, 2025, at 9:25 a.m., of Employee E13, the Licensed Nurse, administering medications to Resident R14, revealed that E13 gave Trelegy Ellipta Inhalation Aerosol Powder Breath Activated 100-62.5-25 MCG/ACT (Fluticasone-Umeclidinium-Vilanterol), 1 puff to inhale to R14. Resident R14 did not rinse (his/her) mouth after inhaling Fluticasone-Salmeterol. It was observed that Licensed nurse, Employee E13 did not encourage or educate Resident R14 to rinse (his/her) mouth after inhaling Trelegy Ellipta Inhalation Aerosol Powder Breath Activated. Review of literature related to the use of Fluticasone-Salmeterol Aerosol Powder and of Trelegy Ellipta Inhalation Aerosol Powder indicated the following procedure after inhaling those inhalers: Rinse the mouth with water after breathing in the medicine, spit out the water, do not swallow it. Interview on November 19, 2025, at 9:27 a.m., with Licensed nurse, Employee E13, confirmed that she was not aware of the need to rinse the mouth after inhalation of Fluticasone-Salmeterol 100-50 MCG/ACT Aerosol Powder or that of Trelegy Ellipta Inhalation Aerosol Powder. 28 Pa. Code: 201.18(b)(1) Management. 28 Pa. Code: 211.12(d)(3)(5) Nursing services.		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based upon interviews with the resident, resident's family and staff interviews, review of clinical records, facility documentation and policies it was determined that the facility failed to ensure a resident admitted with a pressure ulcer received the necessary treatment and services, in a timely manner, consistent with professional standards of practice, to promote healing and prevent infection for one of 26 resident records reviewed (Resident R148). Findings include: Review of facility policy titled, admission assessment dated [DATE] states the assessment is to be completed by a licensed nurse when the patient arrives at the facility, prior to the end of the shift. If all information cannot be obtained prior to the end of the shift, remaining data sections will be completed within 24 hours. Licensed nurses are responsible for completing a physical assessment. Review of facility policy for Wounds/Skin Assessments dated [DATE] states any wound and/or skin impairment will be routinely assessed and treated as ordered. A licensed nurse will assess patients for any skin impairments, including pressure ulcers, Notify provider and/or updates and/or changes to the skin impairments, Obtain new orders, and Provide treatments as ordered. Resident R148 was admitted to the facility on [DATE], diagnosed with Chronic pain syndrome, unspecified severe protein-calorie malnutrition, systemic lupus erythematosus (an autoimmune disease effecting many parts of the body), rheumatoid arthritis (a chronic autoimmune disorder affecting the joints, causing pain and swelling) and infection and inflammatory reaction due to internal left knee prosthesis. Observation and interview with Resident R148 and the resident's spouse, on [DATE], at 1:00 p.m. indicated the facility did not obtain a treatment order for a pressure ulcer, located on the resident's lower, when first admitted. The spouse voiced his concerns, stating, I was so mad, she was here for days without any treatments. Then, the nurse started documenting that they were treating her wound, but they weren't. Review of Resident R148's initial admission assessment dated [DATE], assessed the resident with a pressure wound on the left heel and left calf, bruising on top of the resident's arm and reddened area on the buttocks, failing to assess the pressure area on the resident's lower back. Review of the skin assessment the next day, dated [DATE], assessed the resident with a pressure ulcer on the lower spine measuring, 4.2 x 4.2 x 0.1cm, described as black and necrotic (tissue that has died prematurely). Review of the treatment administration record revealed a physician order was not obtained, nor treated until [DATE], two days after being admitted to the facility. Review of the physician orders dated [DATE], instructed to cleanse wound to lower back with wound cleanser, pat dry, apply Santyl and cover with Border Gauze every evening shift for wound care. Interview with licensed nurse, Employee E3 On [DATE], at 1:00 p.m. during an interview with licensed nurse Employee E3, stated on, [DATE], the nurse observed the treatment dressing on Resident R148's lower spine that was dated [DATE]. Interview with the Director of Nursing on [DATE], confirmed the facility failed to initiate wound care the day of Resident R148's admission to the facility. 28 Pa. Code 211.10(c) Nursing services 211.12(d)(1)(5) Nursing services		