

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

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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395390	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/14/2025
NAME OF PROVIDER OR SUPPLIER Nottingham Village		STREET ADDRESS, CITY, STATE, ZIP CODE 58 Neitz Road Northumberland, PA 17857	
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 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 observation and staff interview, it was determined that the facility failed to maintain food service equipment in accordance with professional standards for food service safety and store food in a sanitary manner in the facility's main kitchen and on two of three nursing units (Station 2 and Station 3). Findings include:An observation of the facility's main kitchen on November 12, 2025, at 9:30 AM with Employee 1, dietary manager, revealed the following: Debris and multiple dried brown liquid spots on the flooring underneath the coffee station area. The wall beside the area was covered in dried liquid splatter, with the broken pieces of drywall on the corner of the wall. A metal utensil rack hanging from the ceiling over the top of a food preparation table had multiple cooking utensils stored hanging from the rack such as spoon, ladles, whisks, and pans uncovered with food contact surfaces exposed to the potential for airborne particles such as dust and potential contamination and food preparation splatter from the table below it. A metal sheet tray located on a shelf under the steamer had grill cleaning utensils stored on it. The tray contained dried debris and dried brown spills. A large white plastic storage bin on wheels located under a preparation table contained a significant amount dried food on the top and exterior sides of the container. A cardboard dispenser box of plastic film covering was observed on the preparation table with dried food and liquid staining on the cardboard. The lower shelves of the dry supply storage room contained dust and debris on the shelf liners. Observation of the Station 2 food service room on November 13, 2025, at 12:54 PM revealed the following:The interior of the microwave was covered in dried food splatter and portions of the interior of the microwave had peeled away in multiple areas exposing rust-colored areas. The interior base of a cabinet located under the sink contained multiple dried liquid spots with a glass jar and vase stored in the cabinet. Observation of the Station 3 refreshment room on November 13, 2025, at 1:05 PM revealed the following:The interior of the freezer above the refrigerator was soiled with debris and frozen spills. The interior base of the cabinet located under the sink area had black debris scattered throughout it with dried brown liquid stains. The above information was reviewed with the Nursing Home Administrator on November 13, 2025, at 1:22 PM. 483.60(i)(2) Store, prepare, food safe and sanitaryPreviously cited 1/30/2528 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 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and staff interview, it was determined that the facility failed to implement an individualized plan of care related to a resident's history of trauma to eliminate or mitigate re-traumatization for two of two residents reviewed for behavior and emotional status (Residents 95 and 101). Findings include: Clinical record review for Resident 95 revealed a revealed a Social History Assessment dated November 11, 2025, for the resident who was admitted on [DATE]. The assessment indicated the resident had a traumatic life event involving the death of his son who was murdered. A review of Resident 95's plan of care revealed a focus area for the resident's trauma indicating the Resident has encountered a trauma that has resulted in physical, social, or emotional harm or life-threatening situation. This trauma has continued to have adverse effects on the residents individual functioning and mental, physical, social, emotional and spiritual well-being: he reports his son was murdered. The plan of care noted a goal that the resident would not have any adverse effects from the trauma, such as behavioral outbursts, mood swings, or physical aggression to oneself or others. A review of interventions/tasks staff should utilize to help Resident 95 meet his trauma goal included continued communication between staff and the resident by showing compassion, develop a rapport with the resident to develop a relationship showing mutual respect and security, encourage family and friends, as appropriate, visits and participation, engage the resident to pursue strengths, choices and a sense of autonomy, offer emotional support and reassurance, and to provide safety to the resident. There were no specific individualized interventions related to the trauma that Resident 95 had indicating how staff are to eliminate triggers (everyday situations that cause a person to re-experience the traumatic event as if it was reoccurring) or mitigate re-traumatization for the resident. Clinical record review for Resident 101 revealed a Social History Assessment dated October 17, 2025, for the resident who was admitted on [DATE]. The assessment indicated the resident had traumatic life events of losing three children, one of which was stillborn (not born alive), and two miscarriages. Review of Resident 101's plan of care revealed a focus area for the resident's trauma indicating the Resident has encountered a trauma that has resulted in physical, social, or emotional harm or life-threatening situation. This trauma has continued adverse effects on the residents individual functioning and mental, physical, social, emotional and spiritual well-being: history of losing children/miscarriages. The plan of care noted a goal that the resident would not have any adverse effects from the trauma, such as behavioral outbursts, mood swings, or physical aggression to oneself or others. A review of interventions/tasks staff are to utilized to help Resident 101 meet the goal noted above included continued communication between staff and resident by showing compassion, develop a rapport with the resident to develop a relationship showing mutual respect and security, encourage family and friends, as appropriate, visits and participation, engage the resident to pursue strengths, choices and a sense of autonomy, and offer emotional support and reassurance. There were no specific individualized interventions related to Resident 101's trauma indicating how staff are to eliminate triggers or mitigate re-traumatization for the resident. Resident 95 and 101's plan of care regarding a history of trauma reflected the same goals and interventions without identifying individualized information as to what staff are to do or not to do for each resident to prevent triggers for each of the resident's trauma. The above information regarding Resident 95 and 101's plan of care regarding trauma related care was reviewed with the Nursing Home Administrator on November 14, 2025, at 9:00 AM. 28 Pa Code 211.12 (d)(3)(5) Nursing services		

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. Based on observation, clinical record review, and resident and staff interview, it was determined that the facility failed to provide resident bathing per preference for one of 32 residents reviewed (Resident 101). Findings include: In an interview with Resident 101 on November 12, 2025, at 11:48 AM the resident stated she is supposed to be getting a shower on Tuesdays and Fridays but does not get them. Resident 101 stated it happened again the day prior on Tuesday, November 11, 2025. Resident 101 stated staff come in early and just wash her up a little in bed and get her dressed but don't take her to the shower. Resident 101 stated her family member had discussed this with facility staff prior, but she still does not get them. Resident 101 stated I was one time a week showers during the day, then it changed to the night, then we got it changed to twice a week like I like it, and I still only get one a week. Clinical record review of Resident 101's bathing task revealed Resident 101 was scheduled upon admission October 14, 2025, to receive a shower on Tuesdays during the day shift. The task was changed to Thursdays on the evening shift on October 16, 2025, back to Tuesday's evening shift on October 21, 2025, and was changed to Tuesdays and Fridays day shift noting per family on October 22, 2025, just as the resident indicated. A review of Resident 101's bathing record revealed the resident received showers on Fridays, October 24, 21, and November 7, but did not receive showers per her preference on Tuesdays, October 28 (bed bath instead of shower), November 4, or November 11, 2025. There was no evidence to indicate Resident 101 refused to be showered. Review of Resident 101's admission MDS (Minimum Data Set - a resident assessment completed at periodic intervals of time to determine resident care needs), dated October 20, 2025, revealed facility staff assessed the resident as being dependent on staff to transfer from bed to chair, or sit to stand, and needing assistance for bathing. Resident 101's missed showers were reviewed with the Director of Nursing (DON) on November 14, 2025, at 10:40 AM. The DON indicated due to the resident being dressed by night shift in the morning the day shift nurse aides thought the resident showers were already completed. 483.10(e)(3) Reasonable Accommodations Needs/Preferences Previously cited 1/30/2528 Pa. Code 211.12(d)(1)(3)(5) Nursing services		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. Based on clinical record review and staff interview, it was determined that the facility failed to ensure assessments accurately reflected a resident's status for one of 23 residents reviewed (Resident 45). Findings include: Clinical record review for Resident 45 revealed a PASRR (Preadmission Screening and Resident Review, assessment required to ensure individuals are not inappropriately placed in nursing facilities and/or receive necessary services in those settings) dated November 2, 2023, that assessed her as having met the criteria for further mental health review by the Department of Human Services (DHS). A letter from DHS dated November 7, 2023, confirmed that Resident 45 met the criteria to require that she receive ongoing mental health services for a serious mental illness that would be arranged by the facility (PASRR II). An annual MDS assessment (Minimum Data Set, an assessment tool completed at specific intervals to determine resident care needs) dated July 24, 2025, incorrectly assessed that Resident 45 was not considered by the state level II PASRR process to have serious mental illness and/or intellectual disability or a related condition. Interview with the Director of Nursing on November 13, 2025, at 12:54 PM confirmed the above MDS error for Resident 45. 483.20(g) Accuracy of Assessments Previously cited 12/06/24 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services		

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. Based on a review of select facility policies and procedures, clinical record review, observation, and resident and staff interview, it was determined that the facility failed to appropriately assess the use of enabler bars for one of seven residents reviewed for accident hazards (Resident 10). Findings include: The facility policy titled, Bed Safety, last reviewed without changes on July 18, 2025, revealed the facility will try to prevent deaths and injuries from the beds and related equipment including the frame, mattress, side rails, headboard, footboard, and bed accessories. Approaches to this included, in part, inspection by maintenance staff of all beds and related equipment as part of the regular bed safety program to identify risks and problems including potential entrapment risks; and review the gaps within the bed system are within the dimensions established by the Food and Drug Administration (FDA). The policy provided by the facility did not further define the gaps. Clinical record review for Resident 10 revealed a diagnosis list that included multiple sclerosis (a breakdown of the protective covering of the nerve causing functional limitations) and generalized muscle weakness. A Minimum Data Set Assessment (MDS, an assessment completed at specific intervals to determine care needs) dated August 11, 2025, revealed that facility staff assessed the resident as having a BIMS (Brief Interview for Mental Status) of 15, which indicated no cognitive impairment. Current physician orders for Resident 10 revealed an order dated August 5, 2025, for a right bed enabler for resident use for positioning. The current care plan for Resident 10 revealed the resident requires assistance with activities of daily living (ADLs) and mobility due to physical limitations. An intervention included a right bed enabler for positioning. An interview with Resident 10 on November 12, 2025, at 11:20 AM revealed the resident was in bed. The resident's bed had bilateral enabler bars attached (the physician order and care plan only indicated a right enabler bar). The resident reported using the enabler bars to help with rolling and repositioning while in the bed. Review of the Side Rail Consent Form revealed that it was signed by the resident and a facility representative and dated October 3, 2025. The form noted the benefits and risks for the use of side rails. There was an X marked next to, I DO CONSENT to the use of side rails. The form did not specify installation parameters of only a right side rail or bilateral side rails. Review of the Side Rail Assessment Form revealed that it was signed by the resident and a facility representative and dated October 3, 2025. The recommendation marked with an X indicated that side rails are indicated and serve as an enabler to promote independence. The form did not specify installation parameters of only a right side rail or bilateral side rails. Review of facility documentation for Resident 10 titled, Bed System Measurement Device Test Results Worksheet, dated October 15, 2025. The form indicated a pass or fail of the entrapment zones measured by facility staff. The form documented bilateral head rails and zones one through four had a circled P which indicated pass. Further review of this documentation revealed documentation of assessment of bilateral foot rails. The form documented bilateral foot rails and zones one through four had a circled P which indicated pass. Resident 10's bed did not have bilateral foot rails at the time of observation, and the facility provided no documentation to indicate that the resident's bed ever had foot rails. There was no measurement recorded on the form for zones five through seven or indication that these zones were assessed as not applicable at the time of the assessment. Zones five through seven were not listed as part of the worksheet. The above information was reviewed in a meeting with the Nursing Home Administrator (NHA) on November 14, 2025, at 11:38 AM. The NHA indicated it was unclear why facility staff assessed the bed as having foot rails and no further documentation was provided by the facility regarding Resident 10's enabler bars. 483.25(n)(1)-(4) Bed Rails Previously cited deficiency 12/6/24 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services		

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on review of select facility policies and procedures, observation, clinical record review, and staff and resident interview, it was determined that the facility failed to ensure a medication error rate less than five percent (Residents 66 and 112). Findings include: The facility's medication error rate was five percent based on 34 medication opportunities with two medication errors. The policy entitled, Administration Procedures for All Medications, last reviewed without changes on July 18, 2025, revealed procedural steps that included to check the MAR (Medication Administration Record, an electronic system used by licensed staff to document the administration of medications) for the physician's order and if unfamiliar with the medication, consult a drug reference, manufacturer package insert, or pharmacist for more information. Observation of a medication administration pass on November 13, 2025, at 8:55 AM revealed Employee 2 (licensed practical nurse) administered Omeprazole (medication that reduces acid in the stomach and relieves symptoms such as heartburn) 40 mg (milligram) delayed release oral capsule to Resident 66. Interview with Resident 66 on the date and time of the medication administration confirmed that she finished her breakfast meal. Review of the Medication Guide section of the package insert for the Omeprazole medication revealed instructions how to take Omeprazole that included to take the medication at least one hour before a meal. Interview with Employee 2 on November 13, 2025, at 9:11 AM confirmed that she administered the Omeprazole medication to Resident 66 as scheduled after her breakfast meal. Employee 2 confirmed that Drugs.com would be a medication reference used when unfamiliar with a medication and confirmed with the surveyor that the instructions for the Omeprazole medication on Drugs.com note that it is best to take Omeprazole one hour before meals. When Omeprazole is taken with food, it reduces the amount of Omeprazole that reaches the bloodstream. Employee 2 confirmed that there was no individualized physician ordered parameter to give the Omeprazole medication outside manufacturer's instructions. The surveyor reviewed the above medication error for Resident 66 during an interview with the Nursing Home Administrator and the Director of Nursing on November 14, 2025, at 10:44 AM. Observation of a medication administration pass on November 14, 2025, at 8:22 AM revealed Employee 4, licensed practical nurse, administered an Ondansetron 8 mg tablet (a prescription medication used to prevent and treat nausea and vomiting), and three Imatinib Mesylate 100 mg tablets (a prescription cancer treatment medication). Clinical record review of resident 112's medication administration record revealed Special Instructions for the administration of Ondansetron reading Give 1 tablet by mouth in the morning for pre-chemo treatment of nausea. Give one hour prior to administration of Imatinib. Further review revealed that the Ondansetron was prescribed with an administration time of 8:00AM, while the Imatinib Mesylate had an administration time of 9:00 AM. The surveyor reviewed the above medication error for Resident 112 during an interview with the Nursing Home Administrator and the Director of Nursing on November 14, 2025, at 10:45 AM. 28 Pa. Code 211.10(a) Resident care policies 28 Pa. Code 211.12(d)(1)(5) Nursing services		

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of select facility policies and procedures, clinical record review, and staff interview, it was determined that the facility failed to ensure an eligible resident received a pneumococcal vaccine for one of five residents reviewed for immunization concerns (Resident 45). Findings include: The facility policy entitled, Pneumococcal Vaccine, last reviewed without changes on July 18, 2025, revealed that all residents will be offered pneumococcal vaccines to aid in preventing pneumonia/pneumococcal infections. Pneumococcal vaccines will be administered to residents (unless medically contraindicated, already given, or refused) per the facility's physician-approved pneumococcal vaccination protocol. Administration of the pneumococcal vaccines or revaccinations will be made in accordance with current Centers for Disease Control and Prevention (CDC) recommendations at the time of the vaccination. Current CDC recommendations for the pneumococcal vaccinations note that the United States uses two types of pneumococcal vaccines. Each individual vaccine helps protect against different serotypes of pneumococcal bacteria. The pneumococcal conjugate vaccines (PCVs: PCV15, PCV20, and PCV21) and the pneumococcal polysaccharide vaccine (PPSV23, Pneumovax 23). Based on shared clinical decision-making, adults 65 years or older have the option to get the PCV20 or PCV21, if they have received both the PCV13 (but not PCV15, PCV20, or PCV21) at any age and the PPSV23 at or after the age of [AGE] years old at least five years after the last pneumococcal vaccine dose. Clinical record review for Resident 45 revealed an immunization form dated November 9, 2023, that indicated Resident 45's responsible party consented to the administration of the Pevnar 20 (PCV20) pneumococcal vaccine. Review of Resident 45's immunization record revealed that she received the following pneumococcal immunizations:Pneumovax (PPSV23) administered March 20, 2007 (before her admission to the facility, at [AGE] years old)Pevnar 13 administered February 23, 2018 (before her admission to the facility, at [AGE] years old)Pneumovax (PPSV23) administered March 22, 2019 (before her admission to the facility, at [AGE] years old) Resident 45 would be eligible for the PCV20 vaccine five years after her last pneumococcal vaccine dose (which would be March 22, 2024). Interview with Employee 3 (registered nurse/infection preventionist) on November 14, 2025, at 9:23 AM confirmed that Resident 45 did not receive the PCV20 immunization that she was eligible for and consented to receive. The surveyor reviewed the above concerns regarding Resident 45's pneumococcal vaccinations during an interview with the Nursing Home Administrator and the Director of Nursing on November 14, 2025, at 10:35 AM. 483.80(d)1)(2) Influenza and Pneumococcal ImmunizationsPreviously cited deficiency 12/06/24 28 Pa. Code 211.12(d)(1)(5) Nursing services		