

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  395428	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  06/12/2025
NAME OF PROVIDER OR SUPPLIER  Northern Dauphin Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE  990 Medical Road Millersburg, PA 17061	

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 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>Based on facility policy review, observations, clinical record review, and resident and staff interview, it was determined that the facility failed to provide services necessary to maintain adequate personal grooming of residents dependent on staff for assistance with these activities of daily living for four of 32 residents reviewed (Residents 7, 26, 93, and 118).</p> <p>Findings Include:</p> <p>Review of the facility policy, titled Activities of Daily Living (ADL), Supporting with a last revised and reviewed date of April 2025, revealed, in part, 3. 'Unavoidable decline' may occur if the resident: c. refuses care and treatment to restore or maintain functional abilities and: (3) the refusal and details of the interventions refused are documented in the resident's clinical record. (5) Appropriate care and services are provided for residents who are unable to carry out ADLs independently, with the consent of the resident, and in accordance with the plan of care, including appropriate support and assistance with: a. hygiene (bathing, grooming, and oral care).</p> <p>Review of Resident 7's clinical record diagnoses included hemiplegia (total or partial paralysis on one side of the body), abnormal posture, contracture left hand (shortening and hardening of muscles, tendons, or other tissue leading to deformity and rigidity of joints), bilateral cataract (a clouding of the eye's natural lens, which can lead to blurred vision), and anxiety (a normal human emotion characterized by feelings of worry, unease, and nervousness).</p> <p>Interview with Resident 7 on June 9, 2025, at 1:30 PM, it was revealed that she had a shower that morning and she does require assistance. Her shower schedule is Monday and Thursday on day shift, at times receives a bed bath and prefers a shower. Per Resident 7 she prefers to be shaved and does not wish to have facial hair.</p> <p>Observations on June 9, 2025, at 1:30 PM, and June 11, 2025, at 12:22 PM, revealed Resident 7 had white facial hair on chin and lower jaw.</p> <p>Further review of Resident 7's clinical record documented showers are scheduled on Monday and Thursday on day shift. On the following dates a bed bath was provided vice a shower: May 15th, 19th, 22nd, 29th, 2025; and June 5th, 2025.</p> <p>Review of progress notes failed to revealed showers were refused.</p> <p>Interview with the Nursing Home Administrator (NHA) on June 12, 2025, at 11:45 AM, it was revealed that shaving should be offered with showers or bathing.</p> <p>(continued on next page)</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
---	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  395428	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  06/12/2025
NAME OF PROVIDER OR SUPPLIER  Northern Dauphin Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE  990 Medical Road Millersburg, PA 17061	
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 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Interview with the Employee 3 (Assistant Director of Nursing) on June 12, 2025, at 11:44 AM, revealed the Resident's preference for shower vice a bed bath should be honored.</p> <p>Review of Resident 26's clinical record revealed diagnoses that included need for assistance with personal care and muscle weakness.</p> <p>Observation of Resident 26 on June 9, 2025, at 10:58 AM, and June 11, 2025, at 12:07 PM, revealed she had half of an inch of facial hair on her chin.</p> <p>Review of Resident 26's care plan had a focus area for an ADL (activities of daily living-hygiene, grooming, etc.) care deficit with an intervention for ensure the resident is well groomed and appropriately dressed, last revised on July 8, 2024.</p> <p>Review of Resident 26's nurse aide task documentation revealed she has a preferred shower schedule of Tuesday and Friday during evening shift.</p> <p>Further review of Resident 26's nurse aide task documentation revealed she hadn't received a shower since May 29, 2025.</p> <p>During an interview with the NHA on June 12, 2025, at 11:39 AM, he revealed Resident 26 has been shaved, and he would expect personal hygiene care including shaving to be offered on shower days and as preferred.</p> <p>Follow-up interview with the NHA on June 12, 2025, at 2:14 PM, he revealed it was likely that Resident 26 had refused a shower since May 29, 2025, and he would expect that to be documented and documentation to indicate the Resident had been reapproached at another time.</p> <p>Review of Resident 93's clinical record revealed diagnoses that included depression (a mood disorder characterized by a persistent feeling of sadness, loss of interest, and changes in thinking, sleep, and appetite) and hypertension (high blood pressure).</p> <p>Interview conducted with Resident 93 on June 10, 2025, at 9:09 AM, revealed she does not always receive a shower twice a week as she is scheduled to, and will receive a bed bath instead. Resident 93 revealed that she prefers to take showers over bed baths.</p> <p>Review of Resident 93's comprehensive care plan revealed an ADL focus area with an intervention for: Bathing: provide the Resident with a sponge bath when a full bath or weekly shower cannot be tolerated; and Bathing: the Resident requires staff participation with bathing/shower; both with an initiation date of March 19, 2024.</p> <p>Review of Resident 93's clinical record revealed that she is to receive showers on Wednesdays and Saturdays.</p> <p>Further review of Resident 93's shower task review for the past 30 days (May 14, 2025 - June 12, 2025) revealed that the Resident received a bed bath on May 17 and 24, 2025; and June 7, 2025.</p> <p>Review of Resident 93's clinical record failed to reveal any progress notes or documentation indicating that the Resident refused a shower on May 17 and 24, 2025; and June 7, 2025.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  395428	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  06/12/2025
NAME OF PROVIDER OR SUPPLIER  Northern Dauphin Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE  990 Medical Road Millersburg, PA 17061	
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 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Interview conducted with the NHA on June 12, 2025, at 10:39 AM, revealed the proper protocol if a resident refuses a shower is to reapproach the resident at another time, and if they continue to refuse to offer a bed bath, notify the nurse, and document the refusal in the resident's clinical record. The NHA revealed he had no additional documents to provide indicating why Resident 93 did not receive a shower on May 17 and 24, 2025, and June 7, 2025. The NHA revealed he would expect the residents to receive a shower on their scheduled shower days if that is their preference.</p> <p>Review of Resident 118's clinical record revealed diagnoses that included need for assistance with personal care and muscle weakness.</p> <p>Observation of Resident 118 on June 9, 2025, at 11:13 AM, and June 11, 2025, at 12:18 PM, revealed she had a quarter of an inch of facial hair on her chin.</p> <p>Review of Resident 118's care plan had a focus area for an ADL care deficit with an intervention for ensure the resident is well groomed and appropriately dressed, initiated on November 3, 2023.</p> <p>Review of Resident 118's nurse aide task documentation revealed she has a preferred shower schedule of Tuesday and Friday during day shift.</p> <p>During an interview with the NHA on June 12, 2025, at 11:39 AM, he revealed Resident 118 has been shaved, and he would expect personal hygiene care including shaving to be offered on shower days and as preferred.</p> <p>28 Pa. Code 201.29(j) Resident rights</p> <p>28 Pa Code 211.12(a)(c)(d)(1)(3)(5)Nursing services</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  395428	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  06/12/2025
NAME OF PROVIDER OR SUPPLIER  Northern Dauphin Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE  990 Medical Road Millersburg, PA 17061	
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 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on facility policy review, clinical record review, and resident and staff interviews, it was determined that the facility failed to provide resident-directed care and services in accordance with professional standards of practice, and consistent with the resident's physician orders, to ensure the resident's highest level of well-being for three of 32 residents reviewed (Residents 93, 136, and 264).</p> <p>Findings include:</p> <p>Review of Resident 93's clinical record revealed diagnoses that included depression (a mood disorder characterized by a persistent feeling of sadness, loss of interest, and changes in thinking, sleep, and appetite) and hypertension (high blood pressure).</p> <p>Interview conducted with Resident 93 on June 10, 2025, at 9:09 AM, revealed that they have been working on getting an appointment scheduled for both of her knees for several months now so that she can get surgery on them to walk again, but has not heard anything about it being scheduled yet. Resident 93 revealed she is not able to walk due to issues with her knees.</p> <p>Review of Resident 93's clinical record revealed a nursing progress note written on August 28, 2024, at 2:57 PM, with text that read, in part, the Resident would like surgery on her bilateral knees for flexion contractures, and a call was placed to a doctor office schedule an appointment to discuss surgical options.</p> <p>Further review of Resident 93's clinical record revealed a nursing progress note written on November 1, 2024, at 4:45 PM, that read, in part, the Resident was transported to the doctor's office for testing, however, it was not able to be completed due to the Resident not being able to straighten their legs for the testing, and a recommendation was placed for the physician to review.</p> <p>Further review of Resident 93's clinical record revealed a nursing progress note written on January 15, 2025, at 11:26 AM, that read, in part, a second orthopedic opinion was to be scheduled for the Resident.</p> <p>Review of Resident 93's current active physician orders revealed an order to schedule orthopedic second opinion per Resident request for bilateral flexion contractures, the Resident wanted to have orthopedic surgery to fix them. Per last orthopedic, surgery is not an option. Schedule with a different office in surrounding area, with an active date of January 15, 2025.</p> <p>Review of Resident 93's clinical record revealed a nursing progress note written on June 11, 2025, at 10:59 AM, that read, in part, staff called an orthopedic office to schedule a second opinion where the Resident requested to be seen for a consult, and the office stated that they did have the Resident's referral scanned into their system but were unsure why it was never scheduled. A consult was scheduled for a second opinion on June 17, 2025.</p> <p>Interview conducted with the Nursing Home Administrator (NHA) on June 11, 2025, at 2:16 PM, revealed that five months seemed like a long time for an orthopedic consult to be scheduled for a resident.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  395428	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  06/12/2025
NAME OF PROVIDER OR SUPPLIER  Northern Dauphin Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE  990 Medical Road Millersburg, PA 17061	
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 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Further interview conducted with the NHA on June 12, 2025, at 11:56 AM, revealed that the original referral was sent to the orthopedic office in January 2025 to schedule an appointment for Resident 93, and that they would expect the facility to have followed up within a week or so if they did not hear back from the office to have to appointment scheduled. The NHA revealed that the unit manager is responsible for follow up on resident's medical appointments being scheduled in a timely manner, and that Resident 93's referral fell through the cracks.</p> <p>Review of Resident 136's clinical record revealed diagnoses that included dementia (a chronic disorder of the mental processes caused by brain disease, marked by memory disorders, personality changes, and impaired reasoning), unspecified lack of coordination, and muscle weakness.</p> <p>Review of Resident 136's physician orders revealed an order for GI (Gastroenterology) Consult, with a start date of January 23, 2025.</p> <p>Review of select facility documentation provided on June 12, 2025, revealed an appointment/consult sheet dated June 11, 2025, that read, GI consult [for] vomiting and syncope (fainting) with bowel movement.</p> <p>Review of Resident 136's nursing progress notes revealed a note on June 11, 2025, that stated MD notified that GI consult has not been scheduled. We are moving forward with scheduling appointment.</p> <p>Interview with the NHA on June 12, 2025, at 11:31 AM, revealed he does not have any information to provide as to why the order for the GI consult from January had not been responded to earlier than the day prior.</p> <p>Review of Resident 136's physician orders revealed the following:</p> <p>CBC and CMP (Complete Blood Count and Comprehensive Metabolic Panel- lab measures) Friday in the AM one time only for monitoring for 1 day, completed date of May 16, 2025.</p> <p>CBC and CMP, Urinalysis with reflex culture (UA C&amp;S- medical test of urine) for abdominal pain one time only, completed on May 20, 2025.</p> <p>Review of an email correspondence from Employee 4 (Licensed Practical Nurse Unit Manager) on June 11, 2025, at 1:25 PM, revealed On May 16, 2025, a CBC and CMP was ordered for [Resident 136], a nurse signed the order in the TAR (Treatment Administration Record- documentation for treatments/medication administered or monitored) and wrote CBC BMP (Basic Metabolic Panel- lab measure) on the lab sheet, which was obtained and already provided. The order was replaced on May 16, 2025, again for CBC CMP this time with UA C&amp;S, this was signed off in the TAR but never written on the lab sheet or rescheduled.</p> <p>Review of select facility documentation provided revealed a fax to the physician on June 11, 2025, asking if he would like the labs completed that were not drawn the previous month per physician order.</p> <p>During an interview with the NHA on June 12, 2025, at 11:31 AM, he revealed he would expect the original labs orders to be completed per physician order, and that they had not yet heard back from the physician if he would like new labs drawn.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  395428	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  06/12/2025
NAME OF PROVIDER OR SUPPLIER  Northern Dauphin Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE  990 Medical Road Millersburg, PA 17061	
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 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident 136's clinical record revealed a note written by Employee 6 (Nurse Practitioner) on May 29, 2025, that stated Monitor blood pressure every shift.</p> <p>Review of Resident 136's clinical record revealed blood pressures every shift failed to be recorded since May 24, 2025, and review of her physician orders revealed she had an active order for blood pressures once weekly, with a start date of February 27, 2024.</p> <p>During an interview with Employee 6 on June 12, 2025, at 10:10 AM, he revealed he would have wanted the blood pressure monitoring every shift to be implemented but the measurements were not obtained.</p> <p>Interview with the NHA on June 12, 2025, at 11:32 AM, revealed the providers should be communicating orders from their notes to nursing staff to be entered, or enter them themselves, rather than just noting orders in their assessments, and he would expect physician orders to be implemented and followed.</p> <p>Review of facility policy, titled Medication Administration- General Guidelines, reviewed April 11, 2025, revealed 1)</p> <p>The individual who administers the medication dose records the administration on the resident's MAR directly after the medication is given. At the end of each medication pass, the person administering the medications reviews the MAR to ensure necessary doses were administered and documented. In no case should the individual who administered the medications report off-duty without first recording the administration of any medications. 6)</p> <p>If a dose of regularly scheduled medication is withheld, refused, or given at other than the scheduled time (e. g. the resident is not in the facility at scheduled dose time, or a starter dose of antibiotic is needed), the space provided on the MAR for that dosage administration is initialed and coded appropriately. An explanatory note is entered in the record. If two consecutive doses of a vital medication are withheld or refused, the physician is notified.</p> <p>Review of Resident 264's clinical record revealed that he was admitted to the facility on [DATE], with diagnoses that included hyperlipidemia (high cholesterol) and hypertension (elevated blood pressure).</p> <p>Review of Resident 264's Medication Administration Record (MAR) dated May 2025, revealed the following orders: Ambien, 5 mg (milligrams), give two tablets by mouth at bedtime for insomnia; Patiromer Sorbitex Calcium Oral Packet, 8.4 GM (grams), give one packet by mouth daily for hyperkalemia (elevated potassium), with instructions to keep in refrigerator; and Fondaparinux Sodium Subcutaneous solution 2. 5mg/0.5mL (milliliters), inject one application subcutaneously (an injection that is given in the fatty tissue, just under the skin) daily for DVT (deep vein thrombosis-blood clot).</p> <p>Further review of Resident 264's May 2025 MAR, revealed no documentation that the Ambien was given on May 14, 2025, at 9:00 PM, as the MAR was blank. On May 21, 2025, the Patiromer Sorbitex Calcium was signed off on the MAR as 16, meaning Hold/See nurse's note. On May 24, 2025, the Fondaparinux Sodium was signed off on the MAR as 16.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  395428	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  06/12/2025
NAME OF PROVIDER OR SUPPLIER  Northern Dauphin Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE  990 Medical Road Millersburg, PA 17061	
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 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident 264's nursing progress note dated May 15, 2025, at 8:57 AM, revealed that that pharmacy was contacted regarding Resident 264's Ambien and that the prescription was filled and would be sent with the next delivery.</p> <p>Review of Resident 264's form titled Controlled Substance Record, revealed the Ambien was signed off as being received on May 15, 2025.</p> <p>Review of Resident 264's corresponding progress note for the Patriomer Sorbitex Calcium dated May 21, at 1:53 PM, revealed that the medication was on order, awaiting arrival of the medication from the pharmacy.</p> <p>Review of Resident 264's corresponding progress note for the Fondaparinux Sodium dated May 24, 2025, at 10:31 AM, revealed that the medication was reordered on this date.</p> <p>Review of Resident 264's clinical record revealed no evidence that the physician was made aware of Resident 264 not receiving his medications on the aforementioned dates and times.</p> <p>In an email correspondence forwarded from the NHA to the surveyor on June 11, 2025, at 12:12 PM, it was revealed that the pharmacy received Resident 264's physical Ambien prescription on May 14, 2025, at 12:26 PM; the Patriomer Sorbitex Calcium was delivered on May 13, 2025, with all of the doses being delivered; and a four day supply of the Fondaparinux Sodium was sent on May 13. On May 15, a 10 day supply was sent of the Fondaparinux Sodium. The medication was then reordered on May 23 and was not delivered until May 24 on the second run, as the pharmacy had to order the medication before it could be sent to the facility.</p> <p>During an interview with Employee 3 (Assistant Director of Nursing) and the NHA on June 11, 2025, at 2:02 PM, Employee 3 stated she would look into why the Ambien was not signed off as being given on May 14, 2025. Employee 3 stated that the Patriomer Sorbitex should have been at the facility, since all doses were sent from the pharmacy. She further stated that since it was to be kept in the refrigerator, the nurse may not have looked there and assumed the medication was not available. She also stated that for the Fondaparinux Sodium, since it is ordered daily and was delivered later on May 24, 2025, nursing staff should have reached out to the physician stating that the medication was not available during the scheduled time of 9:00 AM on May 24, for orders from the physician whether to give the dose later on May 24, when the medication was received, or to skip the dose.</p> <p>In a follow up email from Employee 3 on June 12, 2025, at 10:00 AM, it was revealed that the pharmacy delivers twice a day Monday through Friday, at approximately 2:00 AM and 3-3:30 PM, and there is one delivery on Saturdays and Sundays at around midnight.</p> <p>No additional information was provided regarding the Ambien not being signed off on the MAR on May 14, 2025, or why the Ambien was not received until May 15, 2025.</p> <p>28 Pa. Code 201.18(b)(1) Management</p> <p>28 Pa. Code 211.12(d)(1)(2)(3)(5) Nursing services</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  395428	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  06/12/2025
NAME OF PROVIDER OR SUPPLIER  Northern Dauphin Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE  990 Medical Road Millersburg, PA 17061	
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 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide enough food/fluids to maintain a resident's health.</p> <p>Based on review of facility policy, clinical record review, and resident and staff interviews, it was determined that the facility failed to ensure proper monitoring to maintain acceptable parameters of nutritional status, including monitor resident weights per physician order and inform the physician of significant weight loss, for four of 32 residents reviewed (Resident 5, 123, 136, and 152).</p> <p>Findings include:</p> <p>Review of facility policy, titled Weight Assessment and Intervention, revised March 2022, read, in part, residents are weighed at intervals established by the interdisciplinary team, and are recorded in the medical record. Unless notified of significant weight change, the dietitian will review the weight record monthly to follow individual weight trends over time. Undesirable weight change is evaluated by the physician and multidisciplinary team and are to identify conditions and medications that may be causing weight loss.</p> <p>Review of Resident 5's clinical record documented diagnoses that included diabetes mellitus (the body's ability to produce or respond to the hormone insulin is impaired, resulting in abnormal metabolism of carbohydrates and elevated levels of glucose in the blood and urine), schizophrenia (mental disorder involving a breakdown in the relation between thought, emotion, and behavior leading to faulty perception, inappropriate actions and feelings, affects a person's ability to think, feel and behave clearly), mild intellectual disabilities, obsessive compulsive disorder, lack of coordination, anxiety (a feeling of worry, nervousness, or unease), and dysphagia (difficulty swallowing).</p> <p>Interview on June 9, 2025, at 1:19 PM, Resident 5 stated that she received a salad for lunch but stated that she was not able to chew it and, therefore, didn't eat it. The Resident was unsure if she has had any weight loss.</p> <p>Review of Resident 5's physician orders included weekly weights secondary to weight loss every Tuesday day shift, started January 14, 2025.</p> <p>Resident 5's weight history revealed: October 3, 2024, =185.8lb, November 4, 2024, =183.8lb; December 4, 2024, = 180.4lb; January 8, 2025, = 172.5lb; February 6, 2025, =175.2lb; March 7, 2025= 171lb; April 3, 2025, = 168lb; May 1, 2025, = 166.8lb; June 3, 2025, = 165.8lb. A 14 lb weight loss in 6 months (not significant), weight stable over the past 30 days. Weekly weights were not obtained/documented.</p> <p>Weight change note dated January 8, 2025, read, in part, Resident presents with significant weight loss, physician made aware of all information with the following new orders received for discontinue monthly weights and initiate weekly weights.</p> <p>Interview with the Nursing Home Administrator (NHA) on June 12, 2025, at 12:55 PM, it was revealed the order for weekly weights was not entered into the electronic record to display on the Medication Administration Record, therefore, the weekly weights were not obtained, and they should've been.</p> <p>Review of Resident 123's clinical record revealed diagnoses that included dementia, dysphagia (difficulty swallowing), and muscle weakness.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  395428	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  06/12/2025
NAME OF PROVIDER OR SUPPLIER  Northern Dauphin Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE  990 Medical Road Millersburg, PA 17061	
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 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident 123's clinical record revealed she had a significant weight loss of 6.9% from March 6 to April 1, 2025.</p> <p>Further review of Resident 123's clinical record failed to reveal documentation to indicate the physician was notified of the significant weight loss.</p> <p>Review of Resident 123's nursing progress notes revealed a note written on April 3, 2025, by Employee 8 (Registered Nurse) that read, in part, Resident's weight re-checked today due to significant weight loss since last month. Re-weight is 110.4 pounds in a wheelchair scale which is further off from last month's weight.</p> <p>Further review of Resident 123's clinical record revealed a note written by Employee 2 (Registered Dietitian 1) on April 5, 2025, with a weight assessment in response to the weight obtained on April 1, 2025, with a request for a reweigh measure to verify the weight loss. The note failed to respond to the re-weigh measure in the nursing note from April 3, 2025.</p> <p>Review of Resident 123's progress notes revealed a dietitian note dated April 21, 2025, that read, in part, Recommend weekly weight x 4 for monitoring.</p> <p>Review of Resident 123's clinical record failed to reveal weekly weight measures documented on the weeks of May 5 or 12, 2025.</p> <p>Interview with the NHA on June 12, 2025, at 11:57 AM, revealed that he was not able to locate any documentation indicating the physician was notified of the Resident's weight loss in April 2025, the weekly weights were not obtained because there was a transcription error when the order was entered, and that he would expect doctor notification of weight loss and weekly weights would be obtained as ordered. He further revealed that the reweigh measure obtained on April 3, 2025, was missed by Employee 2 for her assessment review on April 5, 2025, because it was not recorded properly in the electronic health record, and he would expect weights to be recorded properly and communicated to the dietitian.</p> <p>Review of Resident 136's clinical record revealed diagnoses that included dementia (a chronic disorder of the mental processes caused by brain disease, marked by memory disorders, personality changes, and impaired reasoning), unspecified lack of coordination, and muscle weakness.</p> <p>Review of Resident 136's clinical record revealed she had a significant weight loss of 5.3% from April 1 to April 15, 2025.</p> <p>Further review of Resident 136's clinical record failed to reveal documentation to indicate the physician was notified of the significant weight loss.</p> <p>Review of Resident 136's progress notes revealed a dietitian note dated April 22, 2025, that read, in part, Continuing to monitor adherence to diet and weekly weights.</p> <p>Review of Resident 136's physician orders revealed an order for Weekly Weights every day shift every Tuesday for health monitoring, with a start date of January 14, 2025, and an end date of May 14, 2025.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  395428	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  06/12/2025
NAME OF PROVIDER OR SUPPLIER  Northern Dauphin Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE  990 Medical Road Millersburg, PA 17061	
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 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident 136's clinical record failed to reveal weekly weight measures documented on April 22 or 29, 2025.</p> <p>Interview with the NHA on June 12, 2025, at 11:32 AM, revealed that he was not able to locate any documentation indicating the physician was notified of the Resident's weight loss in April 2025, or that the weekly weights were obtained as ordered; and he would expect doctor notification of weight loss and weekly weights would be obtained as ordered.</p> <p>Review of Resident 152's clinical record revealed diagnoses that included bipolar disorder (a mental illness that causes extreme mood swings) and dementia.</p> <p>Review of Resident 152's comprehensive care plan revealed a focus area that the Resident may be nutritionally at risk related to weight loss, date initiated on October 31, 2024, and last revised on December 18, 2024, with an intervention to record and monitor weights, dated initiated on November 5, 2024.</p> <p>Review of Resident 152's clinical record revealed a dietary progress note written on April 15, 2025, at 11:47 PM, that indicated the Resident had a 13.3% weight loss, and their weight dropped from 150 pounds on March 14, 2025, to 133 pounds on March 21, 2025.</p> <p>Further review of Resident 152's clinical record revealed a dietary progress note written on May 14, 2025, at 10:32 PM, that indicated the Resident shows a 21.7% weight loss within 180 days, weighing 129.8 pounds on May 7, 2025.</p> <p>Further review of Resident 152's clinical record failed to reveal any documentation indicating the physician was notified of the Resident's weight loss in April 2025 and May 2025.</p> <p>Interview conducted with the NHA on June 12, 2025, at 1:05 PM, revealed that he was not able to locate any documentation indicating the physician was notified of the Resident's weight loss in April 2025 and May 2025, and would have expected the physician to have been notified of the weight loss.</p> <p>28 Pa. Code 201.14(a) Responsibility of licensee</p> <p>28 Pa. Code 211.12(d)(1)(3)(5) Nursing services</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  395428	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  06/12/2025
NAME OF PROVIDER OR SUPPLIER  Northern Dauphin Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE  990 Medical Road Millersburg, PA 17061	
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 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.</p> <p>Based on clinical record review, facility policy review, and staff interviews, it was determined that the facility failed to ensure Medication Regimen Reviews were completed at least once a month by a consultant pharmacist and responded to in a timely manner by the attending physician or prescriber in a timely manner for two of five residents reviewed (Residents 23 and 72).</p> <p>Findings include:</p> <p>Review of facility policy, titled Medication Regimen Review (Monthly Report), without revision date, failed to reveal an expectation for a timeframe for the medical director or other physician to answer the medication regimen review.</p> <p>Review of Resident 23's clinical record revealed diagnoses of major depressive disorder (a mental disorder characterized by persistent sadness, loss of interest, and a range of other symptoms that significantly interfere with daily life), anxiety (a normal human emotion characterized by feelings of worry, unease, and nervousness), and intellectual disabilities.</p> <p>Review of facility provided pharmacy recommendations dated January 28, 2025, consider discontinuing as needed ondansetron (medication used to prevent nausea and vomiting) and April 30, 2025, consider adding amlodipine (medication used to lower elevated blood pressure) 2.5 milligrams once daily. No documented physician response for the aforementioned recommendations from pharmacy.</p> <p>Review of Resident 23's June 2025, physician orders included ondansetron 8 milligrams every 8 hours as needed for nausea start December 11, 2024, and failed to include an order for amlodipine.</p> <p>Electronic mail communication with the Nursing Home Administrator (NHA) on June 13, 2025, at 8:34 AM, revealed proof of physician response was not available for the aforementioned pharmacy recommendations for Resident 23.</p> <p>Review of Resident 72's clinical record revealed diagnoses of major depressive disorder and anxiety.</p> <p>Review of Resident 72's physician's orders reveal a physician's order for Mirtazapine (antidepressant medication) 15 mg daily with a start date of February 23, 2023, for major depressive disorder.</p> <p>Review of Resident 72's electronic medical record failed to reveal that there was a medication regimen review completed on March 30, 2025, with a recommendation to perform a gradual dose reduction of Resident 72's Mirtazapine. Further review of the medication review revealed it was not addressed by the physician until June 10, 2025, after an inquiry was made for the physician's response to the medication regimen review.</p> <p>Interview with the NHA on June 12, 2025, at 10:45 AM, revealed that they would expect a physician to review and respond to the medication regimen review in a timely manner.</p> <p>28 Pa. Code 211.10(c) Resident care policies</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  395428	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  06/12/2025
NAME OF PROVIDER OR SUPPLIER  Northern Dauphin Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE  990 Medical Road Millersburg, PA 17061	
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 0791</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide or obtain dental services for each resident.</p> <p>Based on review of facility policy, clinical record review, and resident and staff interviews, it was determined the facility failed to assist residents in obtaining routine and emergency dental care for two of 32 residents reviewed (Residents 5 and 93).</p> <p>Findings:</p> <p>Review of facility policy, Dental Services, effective date March 2015, read, in part, dental services will be available to all resident requiring routine and emergency dental care. All requests for dental services should be directed to social services to assure that appointments can be made in a timely manner. For Medicaid residents, the facility will provide the resident without charge, all emergency dental services as well as those routine dental service that are covered under the State plan.</p> <p>Review of Resident 5's clinical record documented diagnoses that included diabetes mellitus (the body's ability to produce or respond to the hormone insulin is impaired, resulting in abnormal metabolism of carbohydrates and elevated levels of glucose in the blood and urine), schizophrenia (mental disorder involving a breakdown in the relation between thought, emotion, and behavior leading to faulty perception, inappropriate actions and feelings, affects a person's ability to think, feel and behave clearly), mild intellectual disabilities, obsessive compulsive disorder, lack of coordination, anxiety (a feeling of worry, nervousness, or unease), and dysphagia (difficulty swallowing).</p> <p>Interview on June 9, 2025, at 1:19 PM, with Resident 5, the Resident stated that she received a salad for lunch but that she was not able to chew it and, therefore, didn't eat it. It was also revealed that she needs to see the dentist, she had teeth removed and was supposed to have dentures made, but that had not occurred.</p> <p>Further review of the clinical record documented Resident 5's payor source is managed care Medicaid program since October 1, 2022.</p> <p>Review of Resident 5's care plan included altered dentition and/or mucus membranes related to oral surgery on October 10, 2024, now edentulous, being fitted for dentures, revised on November 25, 2024.</p> <p>Review of Resident 5's Minimum Data Set (MDS- a comprehensive assessment of a resident's functional capabilities and helps nursing home staff identify health problems) dated March 23, 2025, and February 22, 2025, documented yes for discomfort or difficulty with chewing.</p> <p>Review of Resident 5's progress notes documented oral surgery to remove several teeth on October 10, 2024, and the diet texture was downgraded.</p> <p>Review of MDS note dated November 21, 2024, noted edentulous awaiting dentures.</p> <p>Review of nutrition note dated January 8, 2025, noted a 5% weight loss in 30-days, meal intake 0 to 100%, diet texture down grade could contribute to weight loss.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  395428	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  06/12/2025
NAME OF PROVIDER OR SUPPLIER  Northern Dauphin Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE  990 Medical Road Millersburg, PA 17061	
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 0791</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Interview with Employee 3 (Assistant Director of Nursing) on June 12, 2025, at 11:42 AM, it was revealed that the oral surgery consult didn't note for the Resident to be fitted for dentures, which may be why the consult for new denture wasn't initiate. It was also revealed that the timeframe from surgery to obtain dentures was excessive.</p> <p>Review of Resident 93's clinical record revealed diagnoses that included depression (a mood disorder characterized by a persistent feeling of sadness, loss of interest, and changes in thinking, sleep, and appetite) and hypertension (high blood pressure).</p> <p>Interview conducted with Resident 93 on June 9, 2025, at 11:07 AM, revealed that her two top front teeth are loose, and she has requested but has not been seen by the dentist yet.</p> <p>Review of Resident 93's comprehensive care plan revealed a focus area for: Resident is at risk for altered dentition and/or mucus membranes related to two top front teeth loose, with an initiation date of March 22, 2024; and an intervention to obtain dental consult as necessary, with an initiation date of March 22, 2024.</p> <p>Review of Resident 93's active physician orders revealed an order to consult dental - evaluate and treat as needed, with an active date of March 15, 2024.</p> <p>Review of Resident 93's clinical record revealed a nursing progress note written on November 5, 2024, at 9:49 AM, that read, in part, the Resident has her own teeth, her two front top teeth are loose, and the unit secretary was called to add the Resident to see the house dentist.</p> <p>Further review of Resident 93's clinical record revealed a nursing progress note written on January 15, 2025, at 10:38 AM, that read, in part, the Resident has her own teeth, her two front top teeth are loose, and the unit secretary was called to add the Resident to see the house dentist.</p> <p>Further review of Resident 93's clinical record revealed a nursing progress note written on April 16, 2025, at 11:09 AM, that read, in part, the Resident has her own teeth, her two front top teeth are loose, and the unit secretary was called to add the Resident to see the house dentist.</p> <p>Interview conducted with the Nursing Home Administrator (NHA) on June 12, 2025, at 10:16 AM, revealed they were not able to provide a previous dental consult that was completed for Resident 93, indicating the Resident has not been seen by the dentist.</p> <p>Review of Resident 93's clinical record revealed a nursing progress note written on June 12, 2025, at 7:55 AM, that read, in part, staff spoke with the Resident due to complaints of loose teeth and offered to add the Resident to the dental list to see the dentist next time they are in the facility. The Resident agreed and was added to the dental list.</p> <p>Interview with the NHA on June 12, 2025, at 12:10 PM, confirmed that Resident 93 has been added to the list to see the in-house dentist next time they are in the facility, and that he would have expected Resident 93 to have been seen prior.</p> <p>28 Pa Code 211.15(a)(b) Dental Services</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  395428	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  06/12/2025
NAME OF PROVIDER OR SUPPLIER  Northern Dauphin Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE  990 Medical Road Millersburg, PA 17061	

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 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>Based on observations, review of facility policy, and staff interviews, it was determined that the facility failed to store and serve food/beverages in accordance with professional standards for food safety in two of two nourishment pantries.</p> <p>Findings include:</p> <p>Review of facility policy, Food Storage Areas, revised July 2023, read, in part, all foods should be labeled, dated, and consumed by their safe use by dates.</p> <p>Review of facility policy, Food from Outside Sources, revised July 2023 read, in part, label food and beverages with the resident's name, room number, and date.</p> <p>Observation in the second-floor nourishment pantry on June 9, 2025, at 10:01 AM, revealed one container of 46 ounce moderately thick water and one container of 48-ounce prune juice were open with contents partially removed and not date marked. Packaging on both products documented the products to be good for seven days once opened. observations also revealed three boxes and two metal container with holiday decoration, and one box of smoked sausages that contained no resident identifier and not date marked. On top of refrigerator was two ice cream cones in an open plastic sleeve, not date marked.</p> <p>Interview with Employee 1 (Food Service Director) it was revealed that resident items should contain a resident identifier and be date marked. And when beverage containers are opened, they should be date marked.</p> <p>Observation and interview with Employee 1 on June 9, 2025, at 10:17 AM, revealed one container of 48-ounce prune juice that was open with contents partially removed and not date marked. Employee 1 confirmed that the juice should be date marked when opened.</p> <p>Interview with the Nursing Home Administrator on June 10, 2025, at 2:10 PM, it was revealed that the aforementioned items should be date marked and contain a resident identifier.</p> <p>28 Pa code 211.6(f) - Dietary Services</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  395428	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  06/12/2025
NAME OF PROVIDER OR SUPPLIER  Northern Dauphin Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE  990 Medical Road Millersburg, PA 17061	
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 0887</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status.</p> <p>Based on facility policy review, CDC guidance review, clinical record review, and staff interviews, it was determined that the facility failed to ensure that residents were offered any current COVID-19 vaccinations as required for four of five residents reviewed (Residents 5, 18, 26, and 37).</p> <p>Findings Include:</p> <p>Review of facility policy, titled Coronavirus Disease (COVID-19)- Infection Prevention and Control Measures, reviewed April 11, 2025, revealed This facility follows infection prevention and control (IPC) practices recommended by the Centers for Disease Control and Prevention [CDC] to prevent the transmission of COVID-19 within the facility. The infection prevention and control measures that are implemented to address the SARS-CoV-2 pandemic are incorporated into the facility infection prevention and control plan. These measures include: a. encouraging staff, residents and visitors to remain up-to-date with all COVID-19 vaccine doses; b. providing resources and counseling about the importance of receiving the COVID-19 vaccine;.</p> <p>Review of current CDC guidelines for staying up to date with COVID-19 vaccines dated June 6, 2025, revealed CDC recommends a 2024-2025 COVID-19 vaccine for most adults ages 18 and older .Vaccine protection decreases over time so it is important to get your 2024-2025 COVID-19 vaccine .Getting the 2024-2025 COVID-19 vaccine is especially important if you: Are living in a long-term care facility.</p> <p>Review of Resident 5's clinical record revealed an admission date of January 8, 2016. Review of Resident 5's vaccination history revealed her most recent COVID-19 vaccine was the Fall 2023 vaccine, administered on November 28, 2023.</p> <p>Review of Resident 18's clinical record revealed an admission date of February 23, 2022. Review of Resident 18's vaccination history revealed his most recent COVID-19 vaccine was the Fall 2023 vaccine, administered on January 17, 2024.</p> <p>Review of Resident 26's clinical record revealed an admission date of July 2, 2024. Review of Resident 26's vaccination history revealed no documentation that Resident 26 ever received or offered any COVID-19 vaccinations.</p> <p>Review of Resident 37's clinical record revealed an admission date of April 3, 2019. Review of Resident 37's vaccination history revealed her most recent COVID-19 vaccine was the Fall 2023 vaccine, administered on November 28, 2023.</p> <p>Review of the clinical records for Residents 5, 18, 26, and 37 failed to reveal any evidence that the Resident was offered or were educated on the risks and benefits of the most recent 2024-2025 COVID-19 vaccine.</p> <p>During an interview with Employee 3 (Infection Preventionist/Assistant Director of Nursing) on June 11, 2025, at 1:14 PM, she confirmed that the aforementioned dates for the most recent COVID-19 vaccines were correct for the residents and stated she was unsure why the most recent COVID-19 vaccines have not been offered.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  395428	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  06/12/2025
NAME OF PROVIDER OR SUPPLIER  Northern Dauphin Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE  990 Medical Road Millersburg, PA 17061	
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 0887</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On June 11, 2025, at 2:08 PM, the Nursing Home Administrator was made aware of the concern that the most recent COVID-19 vaccinations had not been offered. No additional information was provided.</p> <p>28 Pa. Code 201.14(a) Responsibility of licensee</p> <p>28 Pa. Code 201.18(b)(1) Management</p> <p>28 Pa. Code 211.12(d)(2)(5) Nursing services</p>		