

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395436	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/06/2025
NAME OF PROVIDER OR SUPPLIER Hickory House Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 3120 Horseshoe Pike Honey Brook, PA 19344	

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 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>Based upon review of facility policy and procedure and review of facility documentation, it was determined the facility failed to report an allegation of abuse for one of one resident reviewed (Resident 101).</p> <p>Findings include:</p> <p>Review of facility policy and procedure titled Abuse - Conducting an Investigation, reviewed May 7, 2025 revealed Complaints and grievances will be investigated as outlined in the Concern and Comment (Grievance) Program</p> <p>Policy and will be reported immediately if the investigation reveals any alleged violations involving neglect, abuse (including injuries of unknown source), and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider, and as required by State law.</p> <p>Review of a grievance filed by Resident 101 on May 8, 2025, revealed Resident 101 felt he was not spoken to nicely and the CNA threw the shirt at him and told him to put it on. [Resident] said [CNA] would not help [Resident] put socks on then left the room and didn't come back.</p> <p>Interview with the Director of Nursing on June 6, 2025, at 10:30 a.m. confirmed that the above abuse allegation was not reported to the State agency as required.</p> <p>28 Pa. Code 201.14(a) Responsibility of Licensee</p> <p>Previously cited 5/31/2024</p> <p>28 Pa. Code 201.18(v)(1)(2) Management</p> <p>Previously cited 5/31/2024</p> <p>28 Pa. Code 201.29(c) Resident Rights</p> <p>Previously cited 5/31/2024</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
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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>Based upon review of facility policy and procedure and review of facility documentation, it was determined the facility failed to investigate an allegation of abuse for one of one resident reviewed (Resident 101).</p> <p>Findings include:</p> <p>Review of facility policy and procedure titled Abuse - Conducting an Investigation, reviewed May 7, 2025 revealed When an incident or suspected incident of resident abuse and/or neglect, injury of unknown source, exploitation, or misappropriation of resident property is reported, the administrator/designee will investigate the occurrence. Protection will be provided to the alleged victim and other residents, such as room or staffing changes as needed to protect the resident(s) from the alleged perpetrator.</p> <p>Review of a grievance filed by Resident 101 on May 8, 2025, revealed Resident 101 felt he was not spoken to nicely and the CNA threw the shirt at him and told him to put it on. [Resident] said [CNA] would not help [resident] put socks on then left the room and didn't come back.</p> <p>Interview with the Director of Nursing on June 6, 2025, at 10:30 a.m. confirmed that the above abuse allegation was not fully investigated.</p> <p>28 Pa. Code 201.14(a) Responsibility of Licensee</p> <p>Previously cited 5/31/2024</p> <p>28 Pa. Code 201.18(v)(1)(2) Management</p> <p>Previously cited 5/31/2024</p> <p>28 Pa. Code 201.29(c) Resident Rights</p> <p>Previously cited 5/31/2024</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>Based on review of clinical records and staff interviews, it was determined that the facility failed to ensure physician's orders were followed for three of three residents reviewed. (Resident 40, Resident 42 and Resident 50).</p> <p>Findings include:</p> <p>Review of Resident 40's clinical record revealed a physician's order for Midodrine (medication used to treat hypotension) 2.5 milligrams (mg) to be administered three times per day and to hold the medication for systolic blood pressure greater than 125 mm/Hg (millimeters of mercury).</p> <p>Review of Resident 40's May 2025 Medication Administration Record (MAR) revealed Resident 40 received Midrodrine 2.5 mg on May 26, 2025 for a blood pressure of 134/43; May 30, 2025 for a blood pressure of 126/46 and May 31, 2025 for a blood pressure of 131/45.</p> <p>Review of Resident 40's June 2025 MAR revealed Resident 40 received Midrodrine 2.5 mg three times on June 2, 2025 for blood pressure readings of 145/50, 135/52 and 135/52 and June 3, 2025 for blood pressure of 131/55.</p> <p>The above information was conveyed to the Nursing Home Administrator and Director of Nursing on June 6, 2025 at 10:00 a.m.</p> <p>Review of Resident 42's clinical record revealed diagnoses including acute congestive heart failure, unspecified protein-calorie malnutrition (critical condition resulting from adequate intake of protein and calories) and dementia (general loss of cognitive abilities, including memory).</p> <p>Review of Resident 42's physician's orders dated May 30, 2025 revealed an order for fluid restriction of 1800 milliliters (ml) in 24 hours- 360 ml on each meal tray, shift 1 -360 ml, shift 2- 360 ml and shift 3 -120 ml every shift for CHF.</p> <p>Review of Resident 42's physician orders dated February 6, 2025 revealed Nursing bedside hydration three times a day. This order was discontinued on June 3, 2025.</p> <p>Review of Resident 42's Fluid Task sheet and Medication Administration Record revealed Resident 42 exceeded the daily fluid allotment as follows: May 31 2025; June 1 2025, June 2 2025 and June 3 2025.</p> <p>Interview with Director of Nursing on June 6, 2025, at 10:15 a.m. confirmed the physician orders were not followed for fluid restriction.</p> <p>Review of Resident 50's clinical record revealed diagnoses including hypertensive chronic kidney disease with stage 1 through stage 4 chronic kidney disease, or unspecified chronic kidney disease. (A medical condition referring to damage to the kidney due to chronic high blood pressure.)</p> <p>Review of Resident 50's physician's orders revealed Metoprolol Succinate ER Tablet Extended Release 24 Hour 25 MG. Give 1 tablet by mouth two times a day for HTN Hold if SBP &lt;110 or HR &lt;60</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident 50s medication administration record (MAR) for the month of March 2025, and April 2025, revealed the facility administered the above medication four times outside of parameters.</p> <p>The facility failed to ensure Resident 50's medication order Metoprolol Succinate ER was administered as ordered.</p> <p>28 Pa. Code 211.12(c)(d)(1)(3)(5) Nursing services</p> <p>Previously cited 5/31/2024</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>Based on clinical record review, observations, and resident interview, it was determined the facility failed to follow a physician's order for oxygen therapy for one of four residents reviewed (Resident 50).</p> <p>Findings include:</p> <p>Review of facility policy, titled Oxygen Administration (Infection Control, Safety, & Storage) last revised 04/08/2025 revealed Change oxygen supplies (e.g., cannula, tubing, humidifier) weekly and when visibly soiled. Equipment should be labeled with resident name and dated when setup or changed out.</p> <p>Review of Resident #50's clinical record revealed there was a current physician's order for the resident to be receiving oxygen therapy via a nasal cannula. The cannula was to be changed every night shift every Wednesday.</p> <p>Observation of Resident #50 on June 3, 2025, at 01:56 p.m. Revealed the nasal cannula (a device used to deliver supplemental oxygen or increased airflow to a patient or person in need of respiratory help). Was dated 05/15/2025. It was soiled with red tinged nasal prongs, 2 brownish red dots also appeared on the side of the cannula on wrapping.</p> <p>Further observation on June 4, 2025, at 09:03 a.m. revealed the same soiled cannula, dated 05/15/2025.</p> <p>Interview with Resident #50 on June 3, 2025, at 01:59 p.m. revealed the resident wears the oxygen often and while in the facility and has it hooked up to an oxygen concentrator.</p> <p>The facility failed to follow a physician's order for oxygen therapy for Resident #50.</p> <p>PA Code 211.10(c) Resident Care Policies</p>		