STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395466	A. Building B. Wing	02/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Milford Rehabilitation and Healthcare Center	264 Route 6 & 209 Milford, PA 18337

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)
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** Based on clinical record review, facility policy review and staff interview, it was determined the facility failed to ensure that nursing services met professional standards of quality in accordance with 42 CFR S483.35 and Pennsylvania Code Title 49, Professional and Vocational Standards, State Board of Nursing, S21.11(c), by permitting registered nurses to access and administer intravenous (IV) medication through an implanted venous port (a surgically placed device located completely beneath the skin that connects directly to a large vein for long-term intravenous therapy) without documented evidence of specialized training and demonstrated clinical competency. This deficient practice occurred for one of six residents reviewed (Resident CR1). Findings include: According to the Pennsylvania Code, Title 49, Professional and Vocational Standards, State Board of Nursing, 21.11 (c) The registered nurse may not engage in areas of highly specialized practice without adequate knowledge of and skills in the practice areas involved. A review of the facility policy titled Implanted Venous Port Accessing, last reviewed April 23, 2025, required that medical personnel who access or de-access an implanted venous port complete additional training and demonstrate proven clinical competency prior to performing the procedure. Clinical record review revealed that Resident CR1 was admitted on [DATE], with diagnoses including malignant neoplasm of the colon (cancer of the large intestine). The resident had a port-a-cath (an implantable vascular access device consisting of a small reservoir with a self-sealing silicone top attached to a catheter that enters a central vein) surgically placed in the upper chest to allow direct access to the bloodstream. Review of Resident CR1's clinical record revealed a nursing progress note dated January 8, 2026, documented that staff were unable to establish a peripheral IV (a short catheter inserted into a vein in the arm or hand for temporary intravenous access) to administer antibiotics. The physician authorized nursing staff to access the resident's port-a-cath using a Huber needle (a specialized non-coring needle designed to puncture the silicone septum of an implanted port without damaging it) to administer intravenous antibiotics. Physician orders dated January 9, 2026, directed staff to administer Ceftriaxone Sodium Injection Solution Reconstituted 250 mg, give 1 gram intravenously once daily for five days for pneumonia (a lung infection that causes inflammation of the air sacs and may fill them with fluid or pus). Review of the January 2026 Medication Administration Record (MAR) (the legal document used by nursing staff to record medication administration, including the date, time, dosage, route, and signature of the administering nurse) showed that from January 9, 2026, through January 13, 2026, Employee 1 (Registered Nurse), Employee 2 (Registered Nurse), and Employee 3 (Registered Nurse) documented administration of the IV antibiotic through the implanted port. Accessing an implanted venous port requires strict sterile technique (methods used to prevent the introduction of microorganisms into sterile body areas) because improper access can introduce bacteria directly into the bloodstream, potentially resulting in a central line-associated bloodstream infection (a serious infection that occurs when bacteria enter the bloodstream through a (continued on next page)

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	central venous catheter), catheter occlusion (blockage of the catheter), infiltration (leakage of fluid into surrounding tissue), bleeding, or air embolism (air entering the bloodstream, which can obstruct blood flow and cause serious harm). The facility failed to provide documentation demonstrating that Employee 1, Employee 2, or Employee 3 completed additional training or validated competency specific to accessing an implanted venous port with a Huber needle for medication administration. The facility did not provide evidence of initial or ongoing competency validation (formal documentation showing that a nurse demonstrated the knowledge and technical skill necessary to safely perform a specific clinical procedure), skills checklists, return demonstrations, formal education records, or internal training specific to port-a-cath access. During an interview on February 20, 2026, at approximately 10:50 AM, the Director of Nursing confirmed that the facility did not maintain evidence of education, specialized training, or competency validation for registered nurses administering medications through a port-a-cath using a Huber needle. 28 Pa. Code 201.20(a) Staff Development. 28 Pa Code 211.12(c)(d)(1)(2)(3)(5) Nursing services.