

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

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No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395473	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/03/2025
NAME OF PROVIDER OR SUPPLIER Pennswood Village		STREET ADDRESS, CITY, STATE, ZIP CODE Route 413 Newtown, PA 18940	
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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. Based on staff interviews, review of facility policy and clinical record review, it was determined that the facility failed clinically assess and notify the resident's physician after a change in condition for 1 out of 16 residents reviewed (Residents R12). Findings include: Review of Resident R12's September 2025 physician orders included the following diagnoses obesity, hypertension (high blood pressure); chronic pain; depression (a mood disorder that causes a persistent feeling of sadness and loss of interest); anxiety (intense, excessive and persistent worry and fear about everyday situations); muscle weakness, and osteoarthritis (the most common form of arthritis, characterized by joint pain and stiffness). Review of the facility policy, Changes in a Resident's Condition or Status revised February 2021 indicated that the facility promptly notifies the resident, his or her attending physician, and the resident's representative of changes in the resident's medical/mental condition and his/her status. Continued review of the policy indicated that prior to notifying the physician or healthcare provider, the nurse will make detailed observations and gather relevant information and pertinent information for the provider, including (for example) information prompted by the Interact SBAR Communication Form (Situation-Background-Assessment-Recommendation) a tool used by nursing staff that includes, but not limited to, an assessment of the resident's current change in condition, including clinical findings. Review of a nursing note documented by Employee E3 (licensed nurse) dated September 20, 2025 at 5:29 p.m. revealed Resident returned to the unit from her apartment around 1710 (5:10 p.m.). Resident has a slurred speech and has difficulty making sentences. Eyes closing while talking to staff. Cheeks flushed. Resident unable to fully pull herself up when using Hoyer lift for sit to stand. Says she is sleepy and would like to take a nap. Resident was placed in her bed around 1725 (5:10 p.m.) Review of the resident's nursing notes did not show evidence that any other follow-up was initiated by licensed nursing staff (e.g. vital signs) regarding the above referenced changes in the resident's medical condition that the resident was observed as exhibiting. Continued review of the nursing notes did not show evidence that the physician was notified regarding the resident's change in medical condition on September 20, 2025 to see if there were any interventions/instructions/treatment and/or further assessments that the physician may have wanted nursing staff to implement for the resident. During an interview with Employee E3 on September 25, 2025 at 12:02 p.m. Employee E3, the note from September 20, 2025 that Employee E3 wrote was reviewed with her. During the interview, Employee E3 confirmed that that she observed the resident having slurred speech, having difficulty making sentences, and explained that the resident was closing her eyes while the resident was speaking to nursing staff upon the resident's return from her leave of absence outside of the facility. During the above referenced interview Employee E3 also confirmed that she did not conduct any clinical assessments of the resident after she observed the resident exhibiting the above referenced changes in her condition. Continued interview with Employee E3 on September 26, 2025 at 10:30 a.m. confirmed that she also did not notify the physician of the resident's change in medical condition. 28 Pa. Code 201.18(b)(1) Management 28 Pa. Code 201.18(b)(2) Management 28 Pa. Code 201.29(a) Resident rights 28 Pa. Code 211.5(f) Clinical records 28 Pa. Code 211.5(g) Clinical records 28 Pa. Code 211.12(c) Nursing services 28 Pa. Code 211.12(d)(1) Nursing services 28 Pa. Code 211.12(d)(2) Nursing services 28 Pa. Code 211.12(d)(5) Nursing services		

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 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit. Based on staff interviews, review of facility policy and review of clinical records, it was determined that the facility failed to ensure that the resident's physician orders were accurate for 1 out of 16 residents reviewed (Resident R12). Findings include: Review of the facility policy, Attending Physician Responsibilities, with a revision date of August 2025 indicated that attending physicians shall be the primary practitioners responsible for providing medical services, and coordinating the healthcare of each resident in the facility. Continued review of the policy indicated that each attending physician will be responsible for the following which included, but not limited to, accepting responsibility for initial and subsequent resident care; supporting discharges and transfers; providing appropriate care, and providing appropriate, timely, and pertinent documentation. The policy also indicated that the attending physician will seek, provide and analyze information regarding a resident's current status, recent history, and medications and treatments to enable safe, effective continuing care, and to support facility compliance with regulations, and care standards. Continued review of the policy also indicated that in consultation with facility staff, the physician will verify that treatments and services, including rehabilitation services, are medically necessary and appropriate in accordance with relevant criteria. Review of Resident R12's September 2025 physician orders included the following diagnosis: obesity, hypertension (high blood pressure); chronic pain; depression (a mood disorder that causes a persistent feeling of sadness and loss of interest); anxiety (intense, excessive and persistent worry and fear about everyday situations); muscle weakness, and osteoarthritis (the most common form of arthritis, characterized by joint pain and stiffness). Continued review of the September 2025 physician order included a physician's order dated March 12, 2025, and monthly thereafter, for the resident to have supervised leave of absence (LOA) visits. Resident may go on LOA supervised with meds. Review of the resident's nursing notes indicated that on May 6, 2025 at 11:26 p.m. the resident returned from her leave of absence for the day, and reported to nursing staff that she spilled hot tea on her thighs. Review of a progress note completed by the nurse practitioner on May 7, 2025, at 9:12 a.m. indicated that the resident had sustained 2nd degree burns on both thighs, as the result of the resident's spilling hot tea on her thigh. Review of a nursing note dated May 28, 2025 at 3:33 p.m. indicated that the resident was off the nursing unit on a leave of absence, and was found on the floor in her independent living apartment after she fell from her motorized scooter. The nursing note indicated that the resident was home alone, and was eventually found by her husband on the floor of her apartment when her returned home. Review of a nursing note on September 20, 2025 at 5:29 p.m. indicated that the resident returned from her leave of absence off the nursing unit, and was observed by nursing staff as having slurred speech, difficulty making sentences, and her eyes closing while the resident was speaking with staff. During an interview with the Director of Nursing (DON) on September 25, 2025 at 9:30 a.m. and the Nursing Home Administrator, the DON regarding the above referenced incidents that occurred when the resident was on supervised leave of absence, per the current physician's order, the DON explained that the physician's order was incorrect, as the resident did not need supervision when she is off the nursing unit. During an interview with the resident's attending physician (Employee E4) on September 22, 2025 at 12:22 p.m. the physician confirmed that the physician order for supervised leave of absence for the resident that had been ordered since March 2025, was incorrect. The attending physician explained that the resident did not have to be supervised when she is on leave of absences. During the interview, the physician also confirmed that physician orders are reviewed monthly by the nurse practitioner and the attending physician. 28 Pa. Code 211.5. (f)(i) Medical records		