

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395477	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/18/2025
NAME OF PROVIDER OR SUPPLIER Laureldale Skilled Nursing and Rehabilitation Cent		STREET ADDRESS, CITY, STATE, ZIP CODE 2125 Elizabeth Avenue Laureldale, PA 19605	

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 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, it was determined that the facility failed to provide a safe, clean, and comfortable environment on two of three nursing units. (Second and Third floors) Findings include:</p> <p>Observations on July 15, 2025, from 7:30 a.m. through 2:30 p.m. revealed the following environmental issues:</p> <p>Roof shingles were missing over the Heritage Wing of the first floor.</p> <p>Ceiling tiles and wallpaper were peeling in bathroom of room [ROOM NUMBER].</p> <p>Ceiling tiles were peeling in bathroom of room [ROOM NUMBER].</p> <p>The wallpaper below the sink and above the window was damaged in room [ROOM NUMBER].</p> <p>A wall was damaged in the bathroom of room [ROOM NUMBER].</p> <p>Wallpaper was peeling behind the bed in room [ROOM NUMBER].</p> <p>The wall near the door of the second floor lounge was damaged.</p> <p>Ceiling tiles in the second floor dining room near the storage door were damaged.</p> <p>Wallpaper was peeling in the activity room by the office door.</p> <p>Ceiling tiles in the second floor in the lounge with the vending machines were damaged.</p> <p>The vent hose for the second floor resident dryer was badly crushed.</p> <p>Ceiling tiles were peeling in the second floor resident laundry room.</p> <p>On the right (window) side of room [ROOM NUMBER], two separate ceiling tiles each had brown stains.</p> <p>room [ROOM NUMBER]-A, had peeling wallpaper in several spots: on the right side of the room, under the window; in the bathroom and the wall outside of bathroom. Below the corner molding trim was dark and discolored.</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
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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	28 Pa. Code 201.14(a) Responsibility of licensee. 28 Pa. Code 201.18(b)(1) Management.		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>Based on observation, clinical record review, and staff and resident interviews, it was determined that the facility failed to provide services to maintain adequate grooming and hygiene for four of 33 sampled residents. (Residents 14, 15, 55, and 62) Findings include: Clinical record review revealed that Resident 14 had diagnoses that included: paraplegia and congestive heart failure. Review of the care plan dated May 30, 2025, revealed that the resident required assistance with activities of daily living (ADLs) including grooming and bathing. On July 15, 2025, at 9:09 a.m., the resident was observed in bed. His fingernails were long and dirty. He was unshaven. The resident stated that his fingernails needed to be cut, and he would like a shave. On July 16, 2025, at 11:23 a.m., and on July 17, 2025, at 10:47 a.m. the resident was observed in bed. His fingernails remained long and dirty. He was unshaven. Clinical record review revealed that Resident 15 had diagnoses that included: dementia and polyneuropathy (nerve damage resulting in numbness in his extremities). Review of the care plan dated June 6, 2025, revealed that the resident required assistance with ADLs including grooming and bathing. On July 15, 2025, at 10:53 a.m., the resident was observed in bed. His fingernails were long and dirty. The resident was non-verbal but nodded when asked if his fingernails needed to be trimmed. On July 17, 2025, at 11:39 a.m. the resident was observed in bed. His fingernails remained long and dirty. Clinical record review revealed that Resident 55 had diagnoses that included: dementia, muscle wasting and atrophy, and heart failure. Review of the care plan dated May 23, 2025, revealed that the resident required assistance with ADLs including grooming and bathing. On July 15, 2025, at 11:43 a.m., the resident was observed in his wheelchair, visiting another resident. His fingernails were long and dirty. The resident stated that his fingernails needed to be trimmed, and he needed assistance. On July 17, 2025, at 1:43 p.m. the resident was observed in his wheelchair in his room. His fingernails remained long and dirty. Clinical record review revealed that Resident 62 had diagnoses that included: diabetes with neuropathy (nerve damage resulting in numbness), hemiplegia and hemiparesis (paralysis and weakness) due to a stroke. Review of the care plan dated June 30, 2025, revealed that the resident required assistance with ADLs including grooming and bathing. On July 15, 2025, at 10:55 a.m., the resident was observed in his room. His fingernails were long and dirty. The resident nodded when asked if his fingernails needed to be trimmed. On July 17, 2025, at 11:41 a.m. the resident was observed in his room. His fingernails remained long and dirty. In an interview on July 18, 2025, at 9:00 a.m., the Administrator confirmed that the residents' fingernails should have been trimmed, and shaving offered when residents are bathed and as needed. 28 Pa. Code 211.12(d)(1)(5) Nursing services.</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 clinical record review and staff interview, it was determined that the facility failed to implement physicians' orders for two of 33 sampled residents. (Residents 47 and 103) Findings include: Clinical record review revealed that Resident 47 had diagnoses that included Alzheimer's disease and hypertension (high blood pressure). A physician's order dated July 20, 2024, directed staff to administer a medication (Bisoprolol Fumarate) three times a day for hypotension. The medication was to be held if the resident's systolic blood pressure (SBP) was lower than 90 millimeters of mercury (mm/Hg) or if the resident's heart rate was less than 60 beats per minute. Review of Resident 47's medication administration records (MARs) revealed that staff administered the medication three times in April 2025, twice in May 2025, four times in June 2025, and three times in July 2025 when the resident's heart rate was less than 60 beats per minute. Clinical record review revealed that Resident 103 had diagnoses that included epilepsy, dementia, and hypertension (high blood pressure). A physician's order dated April 9, 2025, directed staff to administer a medication (Hydralazine) every 8 hours as needed if the resident's systolic blood pressure (SBP) was greater than 140 millimeters of mercury (mm/Hg). Review of Resident 103's medication administration records (MARs) revealed that staff failed to administer the medication as ordered three times in April 2025, three times in May 2025, and once in June 2025, when the resident's SBP was greater than 140. In an interview on July 18, 2025, at 9:00 a.m., the Administrator confirmed that medication for Resident 47 was administered outside of the established parameters and Resident 103's medication was not given per the physician's order. 28 Pa. Code 211.12(d)(1)(5) Nursing services.</p>		